Volume 52 JULY 1959 Number 7

DOES NOT CIRCULATE
UNIVERSITY OF OKLAHOMA
AUG 7 - 1959
MEDICAL LIBRARY

the Journal

OF THE OKLAHOMA STATE MEDICAL ASSOCIATION

"My first wish is to see this plague (war) banished from the earth and the sons and daughters of this world employed in more pleasing and innocent amusements than in preparing implements and exercising them for the destruction of mankind."

G. Washington

wherever STAPHYLOCOCCI PRESENT A PROBLEM

CHLOROMYCETIN

Increased incidence of staphylococcal infections has been reported for Europe, Britain, Australia, New Zealand, and the Americas.[1-5] World-wide reports indicate that many strains responsible for these infections are resistant to commonly used antibiotics.[1-3,5-14] However, this ubiquitous pathogen, according to studies from Germany,[8] Canada,[9] Uganda,[10] New Zealand,[11] England,[12] and the United States,[13,14] remains sensitive to CHLOROMYCETIN.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in a variety of forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

REFERENCES: (1) Smith, I. M.: Staphylococcal Infections, Chicago, Year Book Publishers, Inc., 1958, p. 21. (2) Pryles, C. V.: *Pediatrics* 21:609, 1958. (3) Monro, J. A., & Markham, N. P.: *Lancet* 2:186, 1958. (4) Purser, B. N.: *M. J. Australia* 2:441, 1958. (5) Williams, R. E. O., in National Conference on Hospital-Acquired Staphylococcal Disease, Sept. 15-17, 1958, Atlanta, Georgia, U.S. Dept. Health, Education, and Welfare, Communicable Disease Center, 1958, p. 11. (6) Rountree, P. M., & Beard, M. A.: *M. J. Australia* 2:789, 1958. (7) Mudd, S.: *J.A.M.A.* 166:1177, 1958. (8) Fischer, H. G.: *Deutsche med. Wchnschr.* 84:257, 1959. (9) Royer, A., in Welch, H. & Marti-Ibañez, F.: Antibiotics Annual 1957-1958, New York, Medical Encyclopedia, Inc., 1958, p. 783. (10) Hennessey, R. S. F., & Miles, R. A.: *Brit. M. J.* 2:893, 1958. (11) Markham, N. P., & Shott, H. C. W.: *New Zealand M. J.* 57:55, 1958. (12) Oswald, N. C.; Shooter, R. A., & Curwen, M. P.: *Brit. M. J.* 2:1305, 1958. (13) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* 9:38, 1959. (14) Borchardt, K. A.: *Antibiotics & Chemother.* 8:564, 1958.

Editorials

We Are Playing for Keeps

The House of Delegates approved the Committee on Aging's report, that a plan for a service contract for people over 65 be developed and brought back to an extraordinary session within 90 days for approval, modification or rejection. The time is almost up. To many this is a negative thing—an answer to the Forand Bill—a means of delaying full socialization of medicine. To others it is a positive thing—an opportunity for medicine to solve one of the most pressing problems of medical care—and to do it her own way.

To those who think negatively the Committee's proposal will have to be palatable, for they are interested only in maintaining the status quo while putting off socialized medicine. Those who think positively will be willing to forego some of the palatableness in order to make the program solid, for they are interested in demonstrating to the public that medicine can and will solve medical-economic problems for the public without sacrificing the essential ingredients of the private enterprise system.

The Committee's report will, very likely, present something of a compromise between the negative and the positive. It seems fitting, therefore, at this time to point out certain areas in which the foundation must be deep and strong. We cannot afford a collapse even though we know full well that experience will dictate changes to strengthen and to modify.

The Medical Profession

The weakest link in the chain of structure will be the selfish physician. The Association has been unable to control him and the committee's program cannot be expected to. As long as there is a chance to cheat there will be people even within the medical profession who will. This is not just conjecture. Blue Shield had to revamp its program for extended benefits because some surgeons doubled and sometimes even tripled their usual fees for operations for cancer if the patient had extended benefits. Since vasectomies are not covered by Blue Shield and operations for hydrocele are, the former are shamelessly diagnosed as the latter by some. The Department of Public Welfare is now faced with serious cheating problems, which not only threatens a very fine program but discredits the medical profession.

Neither the Association nor the Committee can build a fence that a pig can't get over, under or through — nor should they try. We are playing for keeps and we are badly in need of another class of membership—a probationary one—a sort of purgatory from which a man must in time either work himself out or be dropped. Instead of fences which will not hold, the spirit of the program could then be defined in terms of its objectives. A committee of colleagues in medicine but not competitors in practice could use this definition to determine unfairness which if it exists can result in probationary membership for the offender. We should not continue to permit membership in the Association to serve as a cloak of respectibility for those who discredit it as well as all medicine.

The Hospitals

The hospitals have much less to fear from socialization of medicine than do we, and it is axiomatic that what is good for us is good for them and vice versa. It is therefore well that both the profession and the hospitals work together. If hospitals are required to pay more to keep a patient in this category than they receive for doing so, they must either go broke or pass the extra cost on to their other patients who are paying their way. The hospitals cannot be expected to support us if we insist on provisions that would jeopardize their very existence.

Morale

If the profession's interest in the success of a program is to be sustained, galling experiences must be avoided. To be stuck with the provisions of a service contract when the patient and hospital are not can be galling indeed. When a patient of his own volition or his family select for him accommodations and services not provided for by his

service contract, then the physician should be released of obligation to abide by the service contract, provided the responsible people are advised of this change in status at the time other accommodations are requested or as soon as the physician is aware of the change.

The Long Stay Patient

This is the most serious impediment to a financial successful program. The immediate solution is not apparent to me, but it seems obvious that no plan can service and maintain a great number of long stay patients at general hospital rates. It is also clear that no hospital can survive and continue to keep those patients after payments are discontinued. It is further clear that a bed occupied by a long stay patient cannot be used for the hospital care of other people who are in need of it.

The experience of the Department of Public Welfare should be a great help in our thinking about the long stay patient. During a 12 month period ending April 30, 1959, the case load of Old Age Assistance was 100,433 and there were 28,717 hospital claims. This means that the number of claims was 28.5% of the number of people enrolled. Of the 28,717 claims, 1,325 were for people who were hospitalized for 30 days or more. It is quite obvious from the record that many of these people were being readmitted over and over again to a general hospital because they had no place to go or could not be managed in a nursing home. The maximum allotted period for one hospital stay is 21 days. The physician's pay for 21 days is the same as for 10 days.

A fair number of physicians figured this one out and discharged the long stay people requiring only custodial care at the end of 10 days, or 14 days putting in another claim for $50.00 that much sooner.

The real lesson here, however, is that the State Welfare Department is paying general hospital rates for convalescent and custodial care which amounts to about $550.00 per month. For nursing home care the department pays $120.00 per month. There is no provision for a facility in between. If the Department could find a means of paying a per diem adequate for the development of decent convalescent facilities—patients could be removed from general hospitals for their convalescent care at a great saving and at the same time provide a stimulus for the establishment of these facilities. This would be a major step toward helping in the solution of the problem of the long stay patient which faces our committee and the hospitals.

Drugs

The physician must be aware of the fact that a major item in any service plan of hospital care is drugs. Drugs are a major item for the pocketbook of these people after they go home, or are in a nursing or convalescent home. In fairness to all concerned where aspirin, or bromides, or chloralhydrate, or phenobarbital, or the simple sulfa drugs, or penicillin will do, there is little need for fancier preparations. The cost of many of the newer drugs is staggering. This does not mean that the sick should be denied anything they really need, only that one be sure that the need exists.

The Cost of a Service Contract

The experience of Blue Cross shows that there are about two and one-half times as may days paid per 1,000 members for hospitalization for the age group 66-70 as for the group age 36-40 and almost four times as many in the group over 70. This obviously means that the cost of a contract to a man over 65 will not be cheap. It may not be within his means at all. Maybe the contract should be written for all ages who have an income less than that contemplated by the committee. You say this isn't fair to the younger ones. It is already being done. The 36-40 group not only helps those older but also younger. The group from 26-50 help those 51-55 who in turn contribute some to the support of the program for those 56-60 who in their turn help the ones who are still older. This, I suppose, is the principle support of all group plans and all insurance—that those who will not use their benefits make it possible for those who will to secure the protection. Perhaps for a tiny increase all along the line the old folks could be offered a plan well within their means and no one would be hurt, and at the same time all people in this income category would be assured the means of obtaining adequate medical care.—*B.H.N.*

Scientific Articles

Inflammatory Disease of the Small Intestine*

J. ARNOLD BARGEN, M.D.

J. Arnold Bargen, M.D., Professor of Medicine at the Mayo Foundation and the University of Minnesota, graduated from Rush Medical College in 1921 and is certified by the American Board of Internal Medicine.

Doctor Bargen is Co-Chairman of the Central Committee of the World Congress of Gastroenterology, a member of the Editorial Board of Gastroenterology and a member of the Advisory Board of Sears-Roebuck Foundation.

In addition, Doctor Bargen is President of the Minnesota State Medical Association, a Delegate from Minnesota to the A.M.A., President of the Minnesota State Board of Medical Examiners and Past President of the American Gastroenterological Association.

This paper is from the Section of Medicine, Mayo Clinic and Mayo Foundation**, Rochester, Minnesota.

REGIONAL ENTERITIS affects mainly young adults and is characterized by abdominal cramps, diarrhea, fever, loss of weight, anemia, and perianal abscesses and fistulas. The lesions usually are limited, in both initial and recurrent cases, to the terminal portion of the small bowel. But although this location is the expected one, regional enteritis may be found anywhere in the small intestine, either in localized or in diffuse form.

The lesions are characterized by a granulomatous, necrotizing, ulcerating, and cicatrizing process and frequently are accompanied by fistulas arising from the lesion in the small bowel and extending into the neighboring viscera or through the abdominal wall.

In one series, 334 were males and 266 females, a ratio of 1.3 to 1. The condition may occur at any age. In this same group, the age at onset varied from 4 to 74 years. However, in 55 per cent of the cases, the onset occurred between the ages of 16 and 30 years.

Of the 600 patients with regional enteritis who came to the Mayo Clinic before 1950, 342 underwent a total of 377 resections of the bowel for this disease at the clinic, and 198 of the patients were not subjected there to any surgical treatment of any kind. This indicates that in the years prior to the present decade surgical treatment was the treatment of choice in regional enteritis. This approach has changed gradually, as will be

*Read at the meeting of the Oklahoma State Medical Association, Tulsa, Oklahoma, May 5, 1958.

**The Mayo Foundation, Rochester, Minnesota, is a part of the Graduate School of the University of Minnesota.

pointed out when results of treatment are considered.

Complications. Abscess and Fistula.—Probably the commonest complication of regional enteritis is an abscess in or around the bowel and the subsequent formation of a fistula. The frequent coexistence of abscesses and fistulas appears to be more than coincidental.

Two general types of abscess and fistula are (1) the intra-abdominal and (2) the ischiorectal. To begin either of these, the ulcerative process in the bowel extends through the wall of the bowel—and this happens frequently. In the intra-abdominal type, extension of the process may perforate a neighboring viscus, thus forming a complete fistula; or on the other hand, if the peritoneum does not adhere firmly and completely to the surrounding parietes, an abscess develops. This abscess may rupture into an adjoining viscus, for the abscess extends in various directions if limiting adhesions are deficient.

Ischiorectal and perirectal abscesses develop from infected anorectal crypts. Such complications in this region are less common than the intra-abdominal; but even so, the frequency of this condition is striking.

Obstruction.—Partial obstruction may occur early in cases of regional enteritis as a result of edema and cellular infiltration of the bowel wall. Later, proliferation of fibrous tissue aids in the production of obstruction, and sometimes the process becomes irreversible. Surgical intervention in this type of case is imperative.

Intestinal Bleeding.—Six per cent of the series of 600 patients mentioned gave a history of initial intestinal hemorrhage. Occasionally the bleeding is in the form of a massive intestinal hemorrhage. The blood may be red, but is more likely to be black and tarry.

Deficiency States.—Various degrees of deficiency states are encountered in the association with the initial and recurrent lesions of regional enteritis. They can represent a number of causes. At times involvement of the bowel, greater than can be demonstrated clinically or roentgenographically, results in a state similar to that seen in the sprue syndrome. This is relatively rare. There is also the factor of gradually diminishing intake of food as a result of anorexia and fear of the colic that occurs after eating. Then, too, the absorptive surface of the bowel is materially interfered with in some of these cases. In the past, deficiency states in the absence of demonstrable recurrence have seemed to support the position that the remaining normal part of the small bowel is unable to perform adequately its function of absorption.

Arthritis.—Polyarthritis of the rheumatoid type, involving particularly the extremities and small joints, was encountered in 4.5 per cent of the 600 patients studied.

Erythema Nodosum and Pyoderma Gangraenosum.—These complications are seen rarely in regional enteritis, as compared to their frequency in ulcerative colitis.

Treatment. — Indications for surgical intervention in regional enteritis are related closely to the complications mentioned. Whereas at one time surgical treatment was suggested as soon as the diagnosis of regional enteritis was made, today surgical intervention is used largely for the complications. The reason for the changed attitude is not the risk of operation but the frequency of recurrence after surgical exclusion or resection.

Of 600 patients, 402 were subjected to definitive surgical treatment; and of these, 400 survived the operation. In 135 of the 400 who survived definitive surgical measures, the disease remained arrested for the duration of this study. In another 135, the disease recurred. Sixty per cent of the recurrences developed within the first year following surgical operation.

The other 198 patients were treated nonsurgically with a variety of methods and adjuncts including diet, sulfonamides, antibiotics, steroids, and roentgen therapy. Because of our facilities, we most often use 130 kv. in treatment rather than 200 kv. The anterior abdominal wall is blocked off into four fields, two on each side of the line extending from the xiphoid to the pu-

bis. We give one field one treatment on one day with about 135 r. If the patient is in fairly good condition, we give the four treatments in four days. If he is not, we divide the treatment into half sessions. Most patients do not get sick enough to require pyridoxine but we usually give it as a precaution. If the patient is stout, or if our 200-kv. machines are free that day, we use 200 kv. with a dose of about 125 to 150 r. as before.

Survival and Recurrence.—Of the 198 patients treated nonsurgically, 123 were known to be alive at the time this study was completed. Twenty-four were known to have died, and 51 were lost to follow-up.

At the end of 10 years after the diagnosis was made, 81.1 per cent of the patients with regional enteritis were alive. This finding is to be compared with an anticipated survival of 97.4 per cent of persons in similar age groups in the general population during a given decade. Thus it can be said that while the problem of recurrence is rather threatening, the problem of survival is not.

In only 39 patients did the disease develop after the age of 50. Only three of these are known to have had a recurrence of the condition. A complete follow-up study of the 39 has not been made, but no reports of recurrence have been received from the others.

Granulomatous Lesions of the Stomach and Upper Part of the Small Bowel

In recent years we have found a nonspecific granulomatous inflammation involving the duodenum and stomach, and at times the jejunum as well, and pathologically resembling the so-called regional enteritis. This is not well recognized, for when Comfort, Weber, Baggenstoss, and Keating wrote their article about it in 1950, only two other cases reported in the literature had included involvement of the duodenum. The condition is relatively rare, but occurs frequently enough to warrant the attention of every physician and particularly those interested in making accurate diagnoses and differential diagnoses of gastrointestinal problems. So far, we have found no better designation for this condition than "nonspecific granulomatous inflammation of the stomach and intestinal tract."

The histories presented by these patients are well illustrated by that of a man first seen in January, 1932, when he was 26 years old, with a history of episodic, dull, diffuse upper epigastric pain, occurring 20 to 30 minutes after meals and associated occasionally with vomiting. These episodes had been occurring for three years. At times the pain was limited to the periumbilical area and then was dull and constant but was aggravated by eating. He vomited once or twice daily, the vomitus consisting of food eaten at previous meals. There was no hematemesis. Roentgenologic studies revealed only abnormal motility in the upper coils of the jejunum associated with some dilatation. Surgical exploration revealed extensive hyperplastic jejunitis involving six to eight feet of jejunum, with the bowel being three or four times larger than normal. The inflammation extended into the mesentery of the bowel. A small amount of straw-colored fluid was found in the peritoneal cavity. The remainder of the bowel appeared normal under gross inspection.

Most of the cases we have seen of this condition have had the following clinical features: (1) a continuous and intermittent upper abdominal distress that is intensified by the ingestion of food, a loss of weight and strength, and nausea and occasional vomiting; (2) diarrhea, steatorrheal and episodic in type; (3) gastric retention demonstrated by a succussion splash and by morning aspiration in the fasting state of larger than normal amounts of gastric content; and (4) evidence of deficiency of absorption.

Roentgenologic evidence indicates disturbance of the motility of one or more portions of the upper part of the gastrointestinal tract, persistent or transitory construction, and proximal dilatation of bowel. Atony and ineffectiveness of peristalsis are typical, and in some cases emptying and dilatation of the stomach and constriction of the first, second, or third portions of the duodenum were found. Constrictions were tubular, without sharply demarcated orad or caudad extremities. Within the constrictions, the

relief pattern of the mucous membrane was markedly subdued or absent. Lesions removed, as they were in some cases, had features similar to those found in regional enteritis except that possibly the evidence of hyperplasia was greater. The tubercles, in particular, were identical microscopically with those described in and pathognomonic of regional enteritis.

The granulomatous lesion and its associated conditions must be distinguished from idiopathic steatorrhea and of course from duodenal ulcer and neoplasm of the upper part of the digestive tract. Sometimes there is enough disturbance of intestinal absorption, giving symptoms of disturbed absorption and macrocytic anemia, hypolipemia, hypoprothrombinemia, and hypocalcemia, to make it difficult to distinguish it from an advanced state of the condition known as nontropical sprue.

Clinically, however, the findings of impaired motility with transitory or permanent constriction of the bowel should distinguish the effects of granulomatous lesion from idiopathic steatorrhea.

Nonspecific Ulcers of the Small Intestine

In addition to the ulcers of regional enteritis and the granulomatous lesions of the upper digestive tract, single nonspecific ulcers may appear in the small intestine.

The etiology of these lesions is usually an enigma. Possible relations to trauma, peptic and tryptic digestion, gastric heterotopia, infection, and infarction have been investigated; but no direct relation has been found.

The prodromal signs and symptoms occasioned by these ulcers are so mild and so indefinite that the patient may not seek medical care until hemorrhage, obstruction, or perforation develops. Occasionally such ulcers are observed at abdominal exploration in cases without previous symptomatology pointing to such a condition. Although this is a rare happening, the possibility is one to be remembered in the diagnosis of indeterminate and rather seevre and episodic abdominal pain.

In some cases, a history of vague abdominal pain is the only symptomatic clue. Most patients, however, have recurrent bouts of intermittent crampy midabdominal pain, whose character and persistence usually suggest partial obstruction of the small bowel. In the cases in which obstruction is most severe, vomiting is a rather constant symptom.

Sometimes early manifestations masquerade as ulcer dyspepsias; in others there are concealed bleeding and a refractory form of anemia. Bouts of alternating constipation and diarrhea sometimes precede the commonly observed phenomena of intermittent partial obstruction of the small intestine. The latter is a very common associated situation, and if a patient has periodic partial or complete intestinal obstruction, this type of ulcer should be kept in mind.

Preliminary roentgenologic surveys of the abdomen give useful information in some of these cases by revealing the presence of gas-filled loops of small bowel, and examination tends to place the obstruction proximal to the ileocecal valve.

In nine patients observed over a period of years, the roentgenologist cautiously introduced a thin suspension of barium in a modified motor-meal technic. In six of the nine it was possible to delineate the level of the obstructing lesions, and in four the roentgenologist's opinion was that the condition had an inflammatory basis. So far as we know, the only treatment in such cases is surgical resection.

Usually solitary but occasionally multiple, these ulcers produce clinical effects by causing intestinal obstruction, by loosing gastrointestinal hemorrhage, or by rupturing and forming an abscess.

This presentation is not concerned with the ulcers found as a result of the impaction of a cholelith or foreign body of some kind in the small intestine, nor is a history of prior irradiation with roentgen rays of any kind considered.

Meckel's Diverticulum

The most common congenital anomaly of the intestinal tract is Meckel's diverticulum. One of every 50 children is said to have it. The next most common congenital anomaly,

namely hypertrophic pyloric stenosis, affects one of every 200. All other congenital anomalies are said to occur in the ratio of one in 1000 or more persons.

There is a "rule of two" that is helpful in remembering some facts about the anatomy of Meckel's diverticulum. It occurs in approximately two per cent of the population. It occurs in two males to one female. The diverticulum is usually located about two feet proximal to the ileocecal valve. Its length averages about two inches. Of course great variations from this average rule have been reported occasionally. Actually, the diverticulum may be located anywhere between the pylorus and the ileocecal valve. Ordinary lengths may vary from 2.5 to 12.5 cm., and a Meckel's diverticulum 56 cm. in length has been reported.

Usually the wall of a Meckel's diverticulum is made up of tissue like that of the adjoining ileum. However, the incidence of heterotopic tissue in Meckel's diverticulum is high. These observations are of some interest when lesions of the diverticulum, such as ulcers, are under consideration.

Symptoms.—It is generally agreed that a quarter of the patients who have Meckel's diverticulum have symptoms of one kind or another. Yet because of the location of the diverticulum the diagnosis is exceedingly difficult. The patients may have distress in the lower abdomen or they may have an atypical ulcer distress. The entire symptom complex of peptic ulcer may be mimicked, except that the pain is usually periumbilical or to the right and below the umbilicus rather than hypochondriac.

The symptoms due to Meckel's diverticulum are not unlike those produced by inflammation of the appendix vermiformis. There may be associated fever, right lower abdominal tenderness, and all the other concomitant symptoms of appendicitis. However, the pain of Meckel's diverticulum is much more likely to be periumbilical. The common distressing complication of Meckel's diverticulum is hemorrhage. This may occur in an acute, massive form, or as recurrent mild episodes of bleeding. When children less than two years of age have bleeding from Meckel's diverticulum, it usually is massive, and it has been so severe as to produce hemorrhagic shock.

Complications. — Gastric mucosa, jejunal and duodenal or colonic mucosa, and pancreatic tissue may be found in Meckel's diverticulum. Gastric mucosa is by far the most frequently found of the tissues mentioned and is the only kind consistently associated with symptoms. In children, heterotopic gastric mucosa is the most frequent cause of symptoms and, as would be expected, peptic ulcer is the most frequent complication resulting from this disorder. The ulcer, when it does occur, is found usually in the intestinal mucosa adjacent to, but not actually in, the heterotopic gastric mucosa. Most often the ulcer is situated at the neck of the diverticulum or in the small intestine just beyond its neck. However, ulceration has been demonstrated in diverticula in which no trace of gastric mucosa was evident.

Diagnosis.—Thus the symptoms and signs indicating the presence of Meckel's diverticulum are those of its complications. Although in some instances constriction of the diverticulum resulting from the outpouring of the secretions from heterotopic gastric mucosa could well cause symptoms, the most common symptom indicative of a disease condition in the diverticulum is the passage of fresh blood from the rectum.

If the disease progresses without surgical intervention, the signs and symptoms of perforation with diffusing peritonitis may appear. If the diverticulum causes intestinal obstruction, the well-known clinical appearance of obstruction is presented.

Few diagnostic aids are of any help in arriving at the finding of Meckel's diverticulum. Theoretically a roentgenologic examination would be of great value, but actually the evidence is unclear because the diverticulum already is full of secretion. The histologic characteristics of Meckel's diverticulum are similar to those of diverticula anywhere in the digestive tract.

Series of 161 Cases.—Weber and Good[1] have reviewed the records of patients who were found to have Meckel's diverticulum at operation at the Mayo Clinic from 1935 through 1946. Of 161 patients operated on,

32 had had preoperative roentgenologic examinations of the small intestine. No roentgenologic evidence of abnormality had been found in 15 of these 32. In six of the 15, the diverticula were incidental findings in the course of operations for other abdominal lesions; in the other nine, the diverticula were considered to be related to the patient's abdominal symptoms and signs. A definite roentgenologic diagnosis of Meckel's diverticulum was made and confirmed at operation in seven of the 32 cases. The roentgenologic diagnosis of ulcerohyperplastic ileitis was made five times. The diagnosis was verified at operation in every instance; but Meckel's diverticulum was present also as an incidental finding in three of these five cases, was involved in the ulcerohyperplastic process in one, and was involved with a linear ulcer on the mucosal surface in the other. In another case, the roentgenologic diagnosis of constricting neoplasm of the ileum was made. At operation the lesion proved to be an ulcerated diverticulum; the inflammation extended to the ileum both proximal and distal to the mouth of the diverticulum. In a further instance, the roentgenologic examination revealed a mild and moderate degree of ileal obstruction but the nature of the obstructing process was not determined. The diagnosis of obstruction was verified at operation, and Meckel's diverticulum was found responsible for it.

Acquired Diverticulum

Just as in the large intestine, acquired diverticulum of the small bowel is a change of old age. In some individuals these diverticula are very few and occur only late in life, in others they occur rather early; but rarely in any instance do they appear before the age of 50.

Sometimes they are very numerous, so that almost the entire small intestine is filled with pockets. Fortunately they rarely become inflamed, but occasionally this happens if food particles get caught and inflammation sets in. Then the symptoms are similar to those of Meckel's diverticulum. More often, acquired diverticula simply cause indigestion and intestinal irritability and are associated with a so-called irritable bowel syndrome.

Seen recently at the clinic have been several patients, all elderly men, with extensive diverticulosis of the small intestine. In one instance the diverticulum has become so large as to cause impaction, secondary inflammation, and intestinal obstruction. This had developed so slowly that the patient presented with a sprue-like syndrome. Excessive excretion of fat in the stools, macrocytic anemia, considerable loss of weight, and periodic abdominal cramps were recorded. A thorough examination revealed an obstructive lesion of the small intestine. Operation was advised, a portion of the bowel was resected, and the patient recovered completely. The macrocytosis eventually disappeared and the stools became normal.

In another patient acute inflammation occurred within several of the diverticula, so that a deficiency syndrome with steatorrhea, macrocytosis, and other accompanying symptoms developed. The macrocytosis and anemia were marked. After a period of suitable diet and injections of B_{12}, the patient's condition returned to normal and the macrocytosis came under control.

The illustrations are cited only to show that occasionally the extensive diverticulosis of the acquired type can cause trouble. Some similar cases are reported in the literature. It is one of the conditions to keep in mind in the differential diagnosis of the small-intestinal lesion.

Gallstone Ileus

Gallstone ileus occurs frequently enough to be considered in any discussion of inflammatory small-bowel disease. The symptoms are those of an acute abdominal episode associated with, or followed by, intestinal obstruction. The following case is one in point:

> A 65-year-old spinster was brought to a Rochester, Minnesota hospital on July 10, 1953. She presented with marked abdominal distention, a temperature of 101° F., a toxic appearance, and sweating; and she obviously was acutely ill from some abdominal catastrophe.
>
> Intravenous fluids were given, a double-lumen tube was passed, antibiotics were administered, fluid balance was established, and in due time the acute phase

of her problem subsided. The abdominal distention was relieved, and preliminary roentgenologic surveys of the abdomen showed a shadow in the right lower quadrant suggestive of a gallstone.

Eventually rectal impaction developed and a gallstone measuring 4 by 2 by 2 cm. was removed digitally from the rectum. This event was followed by complete relief of symptoms. The patient was advised to have the gallbladder removed, but she felt so well afterward that she postponed the procedure, and to this day, she still has her gallbladder.

Of course this is not the customary way of removing gallstones, but it does illustrate how a gallbladder may perforate into the intestine, with the result of an intestinal obstruction associated with a severe inflammatory process.

In most instances surgical relief of the intestinal obstruction is required, and the gallstone is discovered at that time.

Tuberculous Enteritis

Inflammation of the small intestine due to the bacillus of tuberculosis is almost always secondary to pulmonary tuberculosis. Intestinal tuberculosis, which a generation ago was a common disease of the small bowel, is now very rare. Nevertheless, it should be given some consideration in the differential diagnosis of any inflammatory disease of the small bowel, particularly when fairly long stretches of the intestine are involved. The prerequisite to a diagnosis of tuberculous enteritis is demonstration of the primary tuberculosis. Usually the patient with tuberculosis involving the small bowel is very ill, much more so than the typical patient with regional enteritis. The condition usually occurs as a late phase of the pulmonary tuberculosis.

However, it may exist in a hyperplastic form, in which case the individual is not necessarily ill but usually has a palpable abdominal mass that roentgenologic examination reveals to be of an inflammatory nature. Ordinarily treatment of the ulcerative intestinal tuberculosis is supportive, but the hyperplastic form may require resection.

Sarcoidosis

It has been thought by some that sarcoidosis did not exist in the intestine except as part of a generalized sarcoidosis involving especially the liver. However, there is a significant group of cases with a diagnosis of regional enteritis in which the pathologic appearance resembles that of sarcoidosis. Whether this is a real sarcoidosis or only a variant of regional enteritis remains in the realm of speculation. In any event, treatment is the same as that for the patient with regional enteritis.

Postradiation Enteritis

After patients have had extensive roentgen therapy to the abdomen for malignant or other diseases—often many years after—a constrictive inflammatory lesion may develop in a segment or segments of the small intestine. This cannot be differentiated either clinically or roentgenologically from regional enteritis, but in such cases the history is of the greatest importance. The physician should inquire specifically as to what amount of roentgen therapy the patient has received. Occasionally such patients bleed massively, or a bowel obstruction develops, and at the time of surgical exploration a scarred segment of bowel is demonstrated. Areas of telangiectasia, so commonly seen after radiation therapy directed to other regions, are readily demonstrated.

Comment

The subject of inflammatory disease of the small intestine is, of course, much too large to discuss in detail in a single presentation. I have tried to present some diagnostic hints that may help in differentiating these intestinal lesions one from another. I have offered a few practical therapeutic suggestions that I hope will help in the management of some of these conditions. This should not be construed as a complete or even adequate discussion of this very large subject.

REFERENCE

1. Bargen, J. A.: Peptic Ulcer in General Practice. In Sandweiss, D. J.: Peptic Ulcer: Clinical Aspects, Diagnosis, Management. Philadelphia, W. B. Saunders Company, 1951, pp. 611-619.

Mayo Clinic and Mayo Foundation
Rochester, Minnesota

Selection of Pediatric Patients for Cardiac Diagnostic and Surgical Procedures

GLEN G. CAYLER, M.D.

Since graduating from the University of California School of Medicine in 1950, Glen G. Cayler, M.D., has been certified by the American Board of Pediatrics.

Formerly associated with the Children's Hospital, Boston, Doctor Cayler is now Assistant Professor of Pediatrics at the University of Oklahoma School of Medicine. He is a member of the American Board of Pediatrics and the Oklahoma State Heart Association.

THE BASIC PHILOSOPHY in regards to the diagnosis and treatment of patients with congenital heart disease has changed so radically in the past twenty years that it is difficult even for older physicians to recall how little clinical interest there was in these patients in the past. Just two decades ago pathologists were the only group who had any great interest in patients with congenital anomalies of the cardiovascular system. At about this time (1936) Maud Abbott's[1] classic atlas of congenital cardiac disease was published. Soon after this, in 1937, Castallanos[2] first introduced angiocardiographic techniques so that anatomical abnormalities could be studied in vivo. During the next ten years, clinical achievements in this field were rapid. Gross[3] reported the successful closure of a patent ductus; Blalock and Taussig[4] introduced the subclavian-pulmonary artery anastomosis for cyanotic patients. In 1947, Taussig's monograph[5] on congenital malformations was published and for the first time there was good data correlating clinical and anatomical findings. The surgical treatment of coarctation of the aorta was introduced in 1945 by Gross[6] and Crafoord[7] approximately simultaneously. In 1949, Cournand and Baldwin[8] at Bellevue published an account of the clinical application of cardiac catheterization in patients with congenital cardiac deformities. This opened wide the diagnostic door for the clinician.

Great as the strides had been up to this time, however, the field of congenital heart disease was still in its infancy compared to the developments in the last ten years. As recently as 10 years ago, patent ductus arteriosus and coarctation of the aorta were the only congenital cardiac lesions amenable to surgical correction. Patients with the classic Tetralogy of Fallot could be improved but not cured by a shunting operation. There was little or nothing to offer patients with other types of acyanotic and cyanotic con-

This paper is from the Department of Pediatrics and the Children's Memorial Hospital, University of Oklahoma School of Medicine.

genital heart disease even if distress was great. In the past decade the scope of surgery for congenital cardiovascular lesions has greatly increased. Now it is a rare lesion that cannot be approached with at least some hope of possible correction or improvement. Because of the surgical advances, diagnostic techniques have become of major practical importance. In order to select the correct surgical procedure and to predict as accurately as possible the surgical risk, it has become very important to define precisely both the anatomy and the pathophysiology of these defects. We also are learning through diagnostic studies what the patho-physiological course of these defects is and are discovering how inaccurate were some of our previous concepts based only on clinical knowledge.

No infant or child should be denied indicated cardiac studies because he is too sick or too small. As a matter of fact, the more severe the lesion and the symptoms, the more urgent is the need for investigation. There are certainly optimal times for study in relation to medical therapy for failure and infection, but it is not reasonable to expect that infants or children with severe cardiac anomalies undergoing diagnostic procedures should be completely compensated and in good condition. Prolonged procrastination in regards to proceeding with diagnostic studies and operation usually leads to disaster.

Limited incomplete studies such as retrograde arteriograms or venous angiograms or so-called "diagnostic" exploratory thoracotomies are not the answer to cardiac diagnostic problems. The basic procedure in almost all cases should be cardiac catheterization with a careful anatomical and physiological evaluation. This study is certainly complimented by angiographic, indicator dilution and other techniques but these other studies are rarely needed in order to establish the basic defect. The importance of physiological evaluation is illustrated in Figure One. The data on the two patients listed was essentially identical except for the pulmonary vascular resistance. They both had an extremely high pulmonary artery pressure; however, one of the patients (L.S.) was an excellent candidate for operation while the other (C.W.) was an extremely high-risk patient with considerable doubt as to whether the operation should be performed at all. The difference in these two patients is in the relationship between the pulmonary artery blood flow and pressure. In the first patient (L.S.) the pulmonary flow is approximately three times normal, indicating that in spite of the high pressure no irreversible charge had occurred in the pulmonary vessels. In the other patient (C.W.), the pulmonary flow was just slightly greater than the systemic flow and there was a good chance of irreversible pulmonary-vascular changes.

Figure One

PATENT DUCTUS ARTERIOSUS	L.S.	C.W.
Catheter passed through ductus	+	+
Systemic arterial saturation	96%	96%
Aortic pressure (mm. Hg.)	90/50	110/60
Pulmonary artery pressure (mm. Hg.)	90/50	100/60
Flow ratio (pulmonary/systemic)	3/1	1.2/1
Pulmonary vascular resistance (units)	3	15 units

The risk of cardiac diagnostic procedures with present methods of monitoring and better understanding of the patho-physiology of the lesions is extremely small in patients over two or three years of age who are not and have not been in cardiac decompensation. There is also virtually no morbidity to these procedures and the small scar on the arm or leg is usually the most severe residual. The same cannot be said for the risk in small infants or in symptomatic patients with considerable cardiomegaly, present or previous decompensation, syncopal episodes, severe cyanosis, or pulmonary artery hypertension. The risk of a carefully done catheterization in the bad risk group is approximately one per cent. Here, however, we must remember that the risk of the disease is great. It certainly is not unusual for patients in this category to expire a day or two before their appointment in the catheterization laboratory. Figure Two is a summary of the infants and children studied at the Children's Memorial Hospital during the last four months of 1958. All of these patients survived their diagnostic procedure without any significant complications during

Figure Two

CARDIAC CATHETERIZATIONS, CHILDREN'S MEMORIAL HOSPITAL
(8/58 - 12/58)

AGE	NUMBER AND PERCENT OF TOTAL PATIENTS	CONGESTIVE HEART FAILURE	NUMBER OF PATIENTS	DIAGNOSIS
< 1 yr.	7 (22%)	7	5	Atrial Septal Defect
1 - 2 yrs.	5 (16%)	4	6	Ventricular Septal Defect
> 2 yrs.	20	4	3	Patent Ductus Arteriosus
	—		6	Pulmonary Stenosis
Total	32	15 (47%)		
Mortality—0			3	Transposition of the Great Vessels
Serious Complications—1 (3%)			9	Other

the procedure except for severe atrio-ventricular block in one patient. The seriousness of the defect in these patients is attested to by the fact that four (or almost fifteen per cent) have expired due to their cardiac disease since their diagnostic studies. In a series of 1,250 infants and children catheterized at the Boston Children's Hospital since 1950,[9] there was only one death directly related to the procedure, a mortality of less than 0.1 per cent.

Certainly not all infants and children with congenital heart disease need to have special cardiac studies. In some their disease is too minimal to warrant studies. In patients with Ebstein's anomaly the clinical diagnosis is usually definite and the risk of catheterization is known to be quite high. Patients are catheterized because of difficulty in establishing an accurate clinical diagnosis, to judge the severity of a lesion, to evaluate effectiveness of surgical procedures, and to ascertain certain facts, both physiological and anatomical, relative to surgical therapy.

Indications for surgical therapy for patients with congenital heart disease must always be weighed in relation to: (1) the risk of treatment versus the risk of the disease; and (2) the gain to be expected from the treatment. One certainly cannot condone very high risk treatment or operation with little chance of possible gain even in patients with severe disease with poor immediate prognosis. The following three examples are presented to illustrate problems in the selection of patients for cardiac operations.

Patient One (Figure Three)—This is a patient with a small patent ductus arteriosus. The risk of the disease here is principally the risk of subacute bacterial endarteritis. The exact incidence of endarteritis in such a patient is actually unknown; however, it is estimated to be less than two per cent. The risk of surgical division of a small asymptomatic ductus is very small, probably less than 0.5 per cent when done by a surgeon with experience in a well equipped hospital with good anesthesia. The risk of subacute bacterial endarteritis after surgical division is nil. In essentially all cases the decision is in favor of elective division between ages two to eight. This then is an example of a disease which is of extremely low risk and yet for which operation is almost always recommended because: (1) the risk of operation is very small, (2) the patient's circulation is returned completely to normal by the procedure and (3) the one danger of the disease, subacute bacterial endarteritis, is completely eliminated.

Patient Two (Figure Four)—This illustrates a high risk disease, a relatively low risk surgical procedure but a procedure again giving essentially 100 per cent correction. This is a very large patent ductus arterious resulting in congestive heart failure in a small infant. The mortality risk of the disease is approximately 10 to 25 per

Figure Three

SMALL PATENT DUCTUS ARTERIOSUS
(Small Left to Right Shunt; Normal Pulmonary Artery Pressure)
Risk of Disease — minimal
Risk of Surgery — < ½%
Gain from Surgery—maximal
Decision—Elective surgery between 2 - 8 years.

Figure Four

LARGE PATENT DUCTUS ARTERIOSUS
(In Infancy)
(Large Left to Right Shunt;
Pulmonary Hypertension)
Risk of Disease - - - 10-25%
Risk of Operation - - - < 5%
Gain from Operation — maximal
Decision—Early Surgical Correction

Figure Five

LARGE VENTRICULAR SEPTAL DEFECT
(In Infancy)
(Large Left to Right Shunt;
Pulmonary Hypertension)
Risk of Disease - - - - - - - 5-10%
Risk of Operation - - - - - - 25-50%
Gain from Operation - usually maximal, if successful
Decision—Defer operation until age 2-5 years unless patient cannot be controlled medically.

cent. This figure does not include the increased morbidity of survivors in terms of infections, cardiac failure, limitations, and probable permanent effect on growth. The risk of operation is less than 5 per cent.[10] The expected gains are: (1) a circulation returned to normal, (2) elimination of the excessive cardiovascular burden, (3) relief of decompensation, and (4) correction of growth failure.[11] The decision here is to close the ductus as soon as the infant is in optimal condition from medical therapy.

Patient Three (Figure Five)—The third example is that of another high risk disease; however, in this case there is also a high risk in surgical treatment and the decision should usually be to defer surgery. This is an infant with a large ventricular septal defect, large left to right shunt, and in congestive heart failure. The risk of the disease in terms of mortality is actually not as great as one might think if the baby receives optimal medical therapy. This usually means proper digitilization, diuretics, and early treatment of respiratory infections. Almost all these patients will survive infancy when managed in this fashion.[12] Present available data indicates that these infants do not develop pulmonary vascular complications. The risk of closure of a ventricular septal defect in these small infants is between 25 to 50 per cent. The decision in this group of patients, therefore, should be against early operation in most cases. Obviously medical therapy is not the final answer to this problem and there are occasional, though usually rare, infants who are improved little or none by medical measures who indeed are candidates for urgent surgical treatment at a very young age.

The above three examples illustrate how the medical and surgical facts and factors must be weighed in each individual case. The optimal time for operation, the surgical risk, and in some cases the method of the surgical approach in other types of congenital heart disease vary so much with the severity of the lesion and the individual response of the patient that it is difficult to present a rigid schedule for the selection of patients for surgical therapy. The fol-

Figure Six

TYPE OF LESION* ↓	SEVERITY OF LESION→	OPTIMAL AGE FOR OPERATION			OPERATIVE MORTALITY		
		Marked	Moderate	Minimal	Marked	Moderate	Minimal
Patent Ductus Arteriosus		When Diagnosed	2 - 10 years	2-10 years	< 5%	< 1%	< ½%
Ventricular Septal Defect		**	3 - 10 years	Operation Not Indicated	25 - 50% (Infants)	5 - 10%	---
Atrial Septal Defect		3 - 10 years	3 - 10 years	"	5%	< 5%	---
Pulmonary Stenosis		When Diagnosed	3 - 10 years	"	5 - 10%	< 5%	---
Aortic Stenosis		"	3 - 10 years	"	10%	5%	---
Coarctation of Aorta		"	8 - 10 years	"	< 10%	< 5%	---
Tetralogy of Fallot		Shunting Procedure For Infants With "Spells"	Total Repair 3 - 6 years	Total Repair 6 - 12 years	10 - 20%	15 - 20%	10 - 15%

*—Uncomplicated Lesions Only

**—See Text Above

lowing outline (Figure Six) is offered therefore only as a general guide.

Summary

As surgical techniques for the correction of cardiac anomalies have developed, methods for accurate diagnosis have become of major practical importance. Indications for and the risks of diagnostic and surgical procedures are outlined and discussed. The importance of early accurate diagnosis of young infants and children with severe cardiac disease is stressed. The more severe the symptoms in these babies, the more urgent is the need for investigation.

BIBLIOGRAPHY

1. Abbott, M.: Atlas of Congenital Cardiac Disease. New York. American Heart Association, 1936.

2. Castellanos, A., Pereiras, R. and Garcia, A.: LaAngiocardia Grafia Radioopaca. Arch. Soc. Estud. Clinic. Habanna, 9: 31, 1937.

3. Gross, R. E. and Hubbard, J. P.: Surgical Ligation of a Patent Ductus Arteriosus. Report of First Successful Case. J.A.M.A. 112: 729, 1939.

4. Blalock, A. and Taussig, H. B.: The Surgical Treatment of Malformations of the Heart. J.A.M.A. 128: 189, 1945.

5. Taussig, H. B.: Congenital Malformations of the Heart. New York, Commonwealth Fund, 1947.

6. Gross, R. E. and Hufnagel, C. A.: Coarctation of the Aorta. Experimental Studies Regarding Its Successful Correction. New Eng. J. Med. 233: 287, 1945.

7. Crafoord, C. and Nylin, G.: Congenital Coarctation of Aorta and Its Surgical Treatment. J. Thoracic Surg. 14: 347, 1945.

8. Cournand, A., Baldwin, J. S. and Himmelstein, A.: Cardiac Catheterization in Congenital Heart Disease: A Clinical and Physiological Study in Infants and Children. New York Commonwealth Fund, 1949.

9. Rudolph, A. M. and Cayler, G. G.: Cardiac Catheterization in Infants and Children. Pedi. Clinics of N. America. 5: 907, 1958.

10. Rudolph, A. M., Mayer, F. F., Nadas, A. S. and Gross, R. E.: Patent Ductus Arteriosus: A Clinical and Hemodynamic Study of 23 Patients in the First Year of Life. Pediatrics 22: 892, 1958.

11. Engle, M. E., Holswade, G. R., Goldberg, H. P. and Glenn, F.: Present Problems Pertaining to Patency of the Ductus Arteriosus. Pediatrics 21: 70, 1958.

12. Fyler, D. C., Rudolph, A. M., Wittenburg, M. A. and Nadas, A. S.: Ventricular Septal Defect in Infants and Children: A Correlation of Clinical, Physiological, and Autopsy Data. Circ. 5: 933, 1958.

800 N.E. 13th, Oklahoma City, Oklahoma

ASS, *n.* A public singer with a good voice but no ear. In Virginia City, Nevada, he is called the Washoe Canary, in Dakota, the Senator, and everywhere the Donkey. The animal is widely and variously celebrated in the literature, art and religion of every age and country; no other so engages and fires the human imagination as this noble vertebrate. Indeed, it is doubted by some Ramasilus, lib. II., De Clem, and C. Stantatus, De Tempermaente) if it is not a god; and as such we know it was worshiped by the Etruscans, and, if we may believe Macrobius, by the Cupasians also. Of the only two animals admitted into the Mahometan Paradise along with the souls of men, the ass that carried Balaam is one, the dog of the Seven Sleepers the other. This is no small distinction. From what has been written about the beast might be compiled a library of great splendor and magnitude, rivaling that of the Shakespearean cult, and that which clusters about the Bible. It may be said generally, that all literature is more or less Asinine.

"Hail, holy Ass!" the quiring angels sing;
"Priest of Unreason, and of Discords King!
Great co-Creator, let Thy glory shine:
God made all else; the Mule, the Mule is thine!"

G. J.

From the Devil's Dictionary by Ambrose Bierce
—Sagamore Press, Inc.

This is the first of a series of articles prepared for The Journal under the auspicees of the Oklahoma Heart Association and its committee on Professional Education, emphasizing the theme of the Association for the current year.

The Pathogenesis of Congestive Heart Failure

JOHN J. DONNELL. M.D.

Since his graduation from the University of Oklahoma School of Medicine in 1943, John J. Donnell, M.D., has been certified by the American Board of Internal Medicine. In addition to his private practice, Doctor Donnell is Assistant Professor of Medicine at the University School of Medicine.

He is an Associate Fellow of the American College of Physicians, a member of the Oklahoma City Clinical Society and the American Heart Association.

IT SEEMS UNNECESSARY to dwell on the individual features and relative merits of the forward versus the backward theories in the pathogenesis of congestive heart failure. There is general agreement that heart failure begins as a result of inadequate cardiac output; this output may be below normal, normal, or several times the normal level, and still be inadequate for the needs of the moment.

The precise reason for failure of the myocardium is unknown. Richard Bing has utilized catheterization of the coronary sinus in studies of myocardial metabolism; he found normal oxygen consumption and energy production in the failing myocardium, and concluded that failure resulted from an inability of the heart muscle to utilize the available energy for effective contraction.[1] It is known also that the failing myocardium is deficient in potassium, and that this abnormality is corrected when compensation is restored with digitalization. Presumably these changes are related to alterations in cell membrane permeability in the myocardium.

Whatever the cause, with the onset of myocardial failure the ventricle does not

empty completely with systole, the cardiac output diminishes, and arterial filling becomes inadequate. Coincident with inadequate arterial filling retention of sodium and water begins, and this occurs prior to any appreciable elevation of venous pressure;[2] this latter fact is not surprising, since venous pressure represents the state of venous tone as well as volume, and may be normal in spite of significant increase in venous volume. There is considerable evidence also that sodium and water retention may begin before renal blood flow or glomerular filtration rate are demonstrably diminished, and that this retention is incident to increased reabsorption in the distal tubule. Whereas increased venous pressure, decreased renal blood flow and glomerular filtration rate, and glomerulotubular imbalance undoubtedly contribute to the production of edema, some other factor seems to occupy the primary role.

For years it was suspected that a hormonal influence was involved in the mechanics of edema formation in congestive failure. It was known that people with Addison's disease could be caused to develop failure when given excess amounts of desoxycorticosterone, and that this occurred in association with increased sodium and water reabsorption from the distal tubule. Bioassay of the urine of patients with congestive failure did reveal increased amounts of adrenal corticoids. Subsequently in 1955 high aldosterone levels were found in patients with congestive failure and edema, along with reduced output of sodium in the urine.[3, 4]

Aldosterone is produced by the adrenal cortex, although it does not appear to be under pituitary control. It is the most potent of the mineralo-corticoids in its ability to cause retention of salt. The output of aldosterone seems to be regulated by alterations in body sodium. Salt deprivation, excess perspiration and various diuretics increase the output of aldosterone, whereas increased salt intake depresses its production.[5] However, overhydration accomplished by administration of excess water and vasopressin also depresses aldosterone levels, and it thus appears that the output of this hormone is sensitive to changes in blood volume as well as sodium levels.[6] High aldosterone levels in congestive heart failure appear to be related to the inadequate arterial filling which is incident to decreased cardiac output; attempts to maintain arterial volume result in increased aldosterone production, and sodium and water are retained; since inadequate cardiac output remains, a vicious cycle is initiated and progressive edema appears. It is tempting to attribute the leading role in edema formation to increased aldosterone output, but this is obvious oversimplification of a complicated process. However, this hormone may be the missing link in the pathogenesis of congestive heart failure. The recent development of direct aldosterone antagonists—the spirolactones—should be of aid in the study of this problem.[7]

Evidence has favored the "forward failure theory" to this point, as far as initiation of edema is concerned. However, "backward failure" is productive of most of the signs and symptoms of congestive heart failure. As ventricular output becomes inadequate, the diastolic volume and pressure rise, along with a proportionate elevation of pressure in the adjacent atrium. As compensatory mechanisms related to Starling's law, tachycardia, arteriolar vasoconstriction, etc., fail, a rise in venous volume and pressure appears. In the lungs, pulmonary venous engorgement results in exertional dyspnea. Orthopnea and paroxysmal nocturnal dyspnea appear when pulmonary congestion is intensified by the increased return blood flow which occurs during recumbancy. If the pulmonary venous pressure rises above the osmotic pressure, the danger of acute pulmonary edema is great. In the right ventricle, systolic pressure rise is proportional to the degree of elevation of pulmonary venous pressure, so that pressures of 50-60 mm of mercury may occur with left ventricular failure. If pulmonary arteriolar vasoconstriction appears, right ventricular systolic pressures rise accordingly, and with this increased work, eventual right ventricular hypertrophy is inevitable. With the appearance of pulmonary hypertension the individual may experience some relief from orthopnea and dyspnea; since pulmonary hypertension means increased pulmonary re-

sistance, which in turn means decreased flow, the net result is a decrease in pulmonary venous return and engorgement. Although slightly relieved symptomatically, such a patient is worse off than before, since this represents a more advanced stage of his disease. As right ventricular failure appears, the familiar picture of venous distention, passive congestion of the viscera, and further impairment of renal function is seen.

Deserving of separate consideration is the syndrome of high output circulatory failure. Youmans maintains that it is not strictly accurate to apply the term high output heart failure to this syndrome, since it may develop in the absence of myocardial failure.[8] When cardiac failure occurs, this will contribute considerably to the defect; nevertheless, heart failure was not the primary etiology in the beginning, since at that time cardiac output may have been several times normal. Several different etiologies may be responsible for the appearance of high output circulatory failure. Probably the best examples are the arteriovenous fistulae and some cases of Paget's disease of bone; these conditions are usually unassociated with any defect which might contribute to the failure. Beriberi, severe anemia, patent ductus arteriosus, some types of pulmonary disease, and hyperthyroidism are other known causes, but in each of these conditions associated aggravating conditions may exist which contribute to failure. The primary abnormality in this syndrome appears to be the lowered peripheral resistance, as a consequence of which there is a low diastolic, high systolic, but an approximately normal mean blood pressure. The arteriovenous oxygen difference is decreased. It has been shown that renal blood flow and glomerular filtration rate are diminished, the mechanism for which supposedly is a shunting of blood away from the kidney; this latter phenomenon is explained on the basis of the concept that the renal circulation is unable to lower its arteriolar resistance, and blood is thus shunted to other areas of lower peripheral resistance. Sodium and water are then retained as a result of proportionately increased tubular reabsorption. To date there are no reported studies on aldosterone output under such circumstances.

Summary

1. The precise metabolic myocardial defect responsible for heart failure is unknown, but the primary result is an inadequate cardiac output.

2. Sodium and water retention begin when cardiac output becomes inadequate, prior to significant rise in venous pressure or lowering of renal blood flow.

3. Increased aldosterone levels appear to be responsible for this sodium and water retention, attempting to correct the impaired arterial filling which is incident to inadequate cardiac output.

4. Since the inadequate cardiac output continues, the vicious cycle of edema formation is perpetuated. Subsequent elevated venous pressure and decreased renal blood flow contribute to the edema formation, but do not play a primary role.

5. "Forward failure" thus is responsible for initiating salt and water retention, whereas "backward failure" is predominantly responsible for the manifestations of congestive heart failure.

6. High output circulatory failure with edema may occur without associated heart failure, in conditions such as arteriovenous fistulae, Paget's disease of bone, etc.

REFERENCES

1. Blair, J. M., Schafer, H., Siegel, U. L., and Bing, R. J.: Myocardial Metabolism in Congestive Failure, Am. J. Med. 20: 820, 1956.

2. Warren, J. V., and Stead, E. A. Jr.: Fluid Dynamics in Chronic Congestive Heart Failure: An Interpretation of the Mechanisms Producing Edema, Increased Plasma Volume and Elevated Venous Pressure in Certain Patients with Prolonged Congestive Failure, Arch. Int. Med. 73: 138, 1944.

3. Luetscher, J. A., Jr.; Neher, R., and Wettstein, A.: Isolation of Crystalline Aldosterone from the Urine of a Nephrotic Patient, Experientia 10: 456, 1954.

4. Luetscher, J. A., Jr.; Neher, R., and Wettstein, A.: Isolation of Crystalline Aldosterone from the Urine of Patients with Congestive Heart Failure, Experientia 12: 22, 1956.

5. Luetscher, J. A., Jr.: Studies of Aldosterone in Relation to Water and Electrolyte Balance in Man, in Recent Progress in Hormone Research: Proceedings of the Laurentian Hormone Conference 1955, edited by G. Pincus, New York, Academic Press, Inc., 1956.

6. Bartter, F. C.: The Role of Aldosterone in Normal Homeostasis and in Certain Disease States, Metabolism 5: 369, 1956.

7. Liddle, G. W.: Aldosterone Antagonists, Arch. Int. Med. 102: 990, 1958.

8. Youmans, W. B.: High Output Circulatory Failure as a Distinct Syndrome. Modern Concepts of Cardiovascular Disease 26: 389, 1957.

1214 N. Hudson, Oklahoma City, Oklahoma

MEDICAL CENTER

EDITORIAL

Tuberculosis and the Family Physician

The family physician traditionally has played a larger role in the diagnosis of tuberculosis than in its treatment. As emphasized in the review in this journal,[1] tuberculosis has become a much more manageable disease and the need for long-term institutional care has been diminished. The treatment should preferably begin in the hospital; however, the family physician can and should take a larger part in the treatment and clinical management of these patients than he has in the past.

The problem may be illustrated by a few figures. In 1950 in the United States, the average patient remained in the hospital 21 months. By 1956 the duration of hospitalization had decreased to eight months, but the post-hospital drug treatment period had increased to 24 months.[2] In the Oklahoma State Tuberculous Hospitals, the average length of stay in 1957 was seven months and 21 days.[3] The Oklahoma City Veterans Hospital, a pioneer in the definitive treatment of tuberculosis in a general hospital setting, has successfully reduced the length of stay of patients with tuberculosis to four months. The number of active cases not hospitalized in 1957 in Oklahoma was 1188, or slightly more than half the total. There were over a thousand *new* cases in this state in 1957.[3, 4]

As the trend for shorter hospitalization, combined with longer periods of chemotherapy has continued, the role of the family physician has altered. Today he is responsible for the majority of the treatment period.

Tuberculosis still is not an easy disease to treat nor is the treatment routine. It is not enough to identify the location of tuberculosis lesions, but we must also know whether these lesions consist predominently of inflammatory elements or whether necrosis is advanced and cavitation is present and to what extent reparative changes already have taken place.

It is evident that much of the responsibility for its therapeutic program must increasingly fall on the family physician.[5] What tools will he need beyond those he can provide in his office? He will need to have access to *all* the tools which now are provided in tuberculous hospitals, e.g. planigraphy and laboratory facilities for drug resistance studies. He will need to have a cooperative liaison with inpatient hospital services, and lastly he will need to have the most recent information on the treatment of tuberculosis.

REFERENCES

1. Burke, Richard M.: Present-day treatment of tuberculosis. Journal of Oklahoma State Medical Association.
2. Parke, Davis Products: Patterns of disease.
3. Oklahoma Tuberculosis Association Program of Work 1959-60.
4. Mathews, Grady F., and Burke, Richard M.: Tuberculosis in Oklahoma (Oklahoma State Health Department Bulletin).
5. Muschennheim, Carl: Tuberculosis and the family physician. Abstracts on Tuberculosis and Other Respiratory Diseases, issued by National Tuberculosis Association, Vol. 31, No. 6, June 1959.

J.F.H.

Present-Day Treatment of Tuberculosis

RICHARD M. BURKE, M.D.

Richard M. Burke. M.D., graduated from the University of Minnesota Medical School in 1930. He is a Fellow of the American College of Physicians and the American College of Chest Physicians.

In addition to his private practice, Doctor Burke is Associate Professor of Medicine at the University of Oklahoma School of Medicine.

THE DEVELOPMENT of antituberculosis drugs has revolutionized the treatment of tuberculosis. This has occurred in a few short years, during which time older measures have been discarded or modified as an increasing dependence is placed on chemotherapy.

Treatment in the past consisted of rest, diet, and collapse measures. Antimicrobial agents have brought a more complex and demanding therapy for the physician to administer. Treatment is also more complex because the patients are older. Once tuberculosis was a disease of young adults. Now it is predominantly a problem among older people. The disease can develop from infection acquired decades earlier. Older people are still suffering from the effects of heavy exposure to infection in their youth, while the young adult of today has not been exposed to the degree that his elders were.

In this paper we shall outline the use of drugs and discuss briefly the other therapeutic measures employed. The treatment of tuberculosis, once the domain of the specialist, is now more within the province of the general practitioner.[1] These comments may be of particular help to the generalist who undertakes to guide the patient along the long road to recovery.

Streptomycin became generally available in 1947 and para-aminosalicylic acid (PAS) two years later. The effective employment of these drugs began about 1950, with the observation that the intermittent use of streptomycin with daily PAS greatly delayed the emergence and dominance of resistant tubercle bacilli.[2] With dual therapy reducing the problem of drug resistance, it was soon agreed that all active tuberculosis should be treated with drugs, regardless of the extent or location of the disease. In 1951 came isonicotinic acid hydrazide (isoniazid).[3] This drug has proven in many ways to be superior to streptomycin and other drugs that have since been developed. Isoniazid appears to interfere with the enzyme metabolism necessary for the growth of tubercle bacilli, thus enabling body defenses to gain the ascendency over the organism.[4] Various antibiotics have been shown to be most effective against susceptible microbes when they are actively multiplying. This is true of the antituberculosis drugs which appear to act only at the time of cell division.[5]

Treatment of Early Infections

As the value of the drugs in clinical tuberculosis became established, the next step was that of exploring their effects in early infection with the tubercle bacillus. At present, drugs are recommended for infants under three years having only a positive tuberculin test. Studies done thus far indicate that it sharply reduces potential progression and dissemination from the primary focus.[6] In children above three having only a positive tuberculin reaction, drugs are ordinarily not employed. Very little progressive tuberculosis is encountered in childhood.

Another limited use for antimicrobial drugs is in treating the person who converts his tuberculin reaction from negative to positive within a short known interval (approximately six months).

Experimental Studies

There are still broader potential uses for chemoprophylaxis under study. For example, in Oklahoma County some members of households with a known case of tuberculosis are being given isoniazid for a year. This is part of a nationwide study. A state project

involves persons with silicosis who are given isoniazid in an effort to determine how much protection it will afford them in preventing tuberculosis.

BCG Vaccine

At this point, it seems not amiss to mention BCG vaccine. It has been in use since 1921 but still its merits are debated.[7] BCG confers some transitory immunity. It has a limited place when the immediate danger of infection is high; for example, when an active case of tuberculosis remains in the home. In our opinion, the limited amount of protection provided does not warrant its widespread use in America. The advisory committee on BCG of the Public Health Service recommends that its use be restricted to high risk situations.[8] We have used BCG for a number of years among children in a poor environment where there is a known active case in the home. During the past two years, our interest in BCG has been diverted by isoniazid chemoprophylaxis, and as a result we are using less vaccine. The decision as to using BCG comes up most often when the exposure risk is high and weakness in other methods of control are evident.

Hospital Care

Hospital care should supplement drug therapy in the presence of active tuberculosis. This provides a sheltered environment where all treatment facilities are readily available. Prolonged strict rest is no longer employed, but the hospital has a major role to play in isolating, establishing the pattern of treatment, performing the necessary surgery, and beginning the rehabilitation of the patient.[9]

Major Drug Programs

There are a few basic drug programs which are initially employed in treatment. The cooperative studies started and continued by the VA and Armed Forces group thirteen years ago have been of great help in establishing the merit of these programs.[10]

The three common drug combinations are: (1) isoniazid (INH) plus para-aminosalicylic acid (PAS); (2) isoniazid plus streptomycin (SM); (3) streptomycin plus para-aminosalicylic acid. The dosage for INH is 5-15 mg/kg. More will be mentioned later regarding dosage of this drug. The average adult daily dosage for PAS is 12-16 grams. The salts, sodium, potassium, and calcium are a little less irritating to the stomach than the acid preparation. They require a slightly larger dose (0.5 gm. of acid is equal to 0.365 gm. of sodium para-aminosalicylate). Toxic reactions to PAS include fever, skin rash, and gastrointestinal intolerance. To cope with gastrointestinal distress, it is wise to sharply reduce dosage for a few days and slowly increase up to tolerance. A trial of some of the many special preparations of PAS claiming lessened gastrointestinal irritation may be rewarding.

Streptomycin is usually given one gram intramuscularly twice a week. Ordinarily this has proven to be adequate dosage, but in recent extensive disease it may be used daily for about three months before starting intermittent administration. The results are slightly better with daily administration. Dihydrostreptomycin is not employed for long-term therapy because of its ototoxicity. Streptomycin is more prone to cause vestibular damage, but this seldom occurs with conventional dosage. Strepoduocin, 0.5 gm. each of streptomycin and dihydrostreptomycin, was introduced with the purpose of lessening neurotoxicity. Its use has not found much favor as apparently it causes about as much damage as dihydrostreptomycin alone. With the intermittent use of streptomycin, eighth nerve impairment is seldom encountered.

It is generally agreed that two drugs should be used to combat the emergence of drug resistant bacilli and ordinarily adding a third drug has little long-term advantage over two. There should be no concern about using the two best drugs simultaneously (INH-SM). All initial treatment cases should include INH with treatment continued for a year, or for at least six months after the disease has been classified as inactive. The average length of treatment in those with advanced disease is about two years. In minimal or non-cavitary disease exhibiting a favorable trend, there is a minority of physicians who use only INH.[11] We do not favor this but stop the second drug after six months and continue with

INH alone in some instances. The best initial combination for cavitary disease appears to be INH-PAS rather than INH-SM or SM-PAS. After 6-8 months of treatment, if the cavities have not closed or exhibit a very definite favorable trend, pulmonary resection is best employed. To continue longer invites drug resistance, even if the sputum is negative.

Other Drugs

The second line of drugs include viomycin, pyrazinamide, and cycloserine. Viomycin is a member of the streptomyces family. The average adult dose is 2 gms. twice a week intramuscularly. Its bacteriostatic activity ranges between streptomycin and PAS. Renal damage is occasionally encountered, but it is rare with conventional dosage. Viomycin is most commonly used as a substitute for streptomycin when resistance or intolerance to this drug is encountered.

Pyrazinamide (pyrazinoic acid amide) is an oral drug of particular value for short-term use (3-6 months) combined with isoniazid. This drug's potential hepatotoxicity merits caution in its use. Some investigators report that measurements of serum enzyme levels forewarn of hepatic damage earlier, although with less specificity than the liver function tests commonly used.[12] It occasionally is employed preceding and after operation in a patient with drug-resistant organisms. The average dosage ranges from 1.5 to 3 gms. daily. Its use is best confined to hospital patients where appropriate supervision can readily be maintained.

Cycloserine, another derivative of the streptomyces family, was introduced in 1954. When used alone, it proved to be rather weak, but in combination with INH it has been fairly effective. It can be neurotoxic. This is manifested by emotional and neuropsychiatric upsets. These symptoms, however, are infrequent with the present daily oral dosage of 500 mg. Its use is not contraindicated in psychiatric patients. It is most frequently used along with INH in patients with drug resistance problems.

Streptovaricin is derived from streptomyces varibilis. Its in vitro activity against the tubercle bacillus was encouraging but clinical trial has not been very promising. Still another derivative of streptomyces is kanamycin, marketed at Kantrex. The Japanese reported favorably on its use. Thus far it appears to be rather toxic (auditory and renal). Trials (1.0 gm. three times a week with PAS) are in progress, but at the moment its use is not advised.

The oxytetracyline drugs have a slight tuberculostatic effect and can be used in combinations with one of the three top tuberculosis drugs when drug resistance problems are encountered. The dosage is 1-2 gms. daily.

We do not favor the combination of two drugs in one preparation. Several products are on the market combining INH with streptomycin and PAS. Proper effective dosage seldom can be regulated when such preparations are used.

In treating uncomplicated primary tuberculosis (positive tuberculin test only) for infants up to three years, it appears that one drug is satisfactory. INH, in dosage of 10 mg/kg. daily for a period of one year, may be used. If PAS is also employed, the dosage is 200 mg/kg. daily.

For recent (within six months) tuberculin converters of all ages, INH 5 mg/kg. daily for 9-12 months is recommended.

Bacterial Sensitivity Studies

Bacterial sensitivity studies are essential in the management of tuberculosis. Soon after streptomycin was introduced the problem of drug resistance was quickly brought into prominence. When used alone, strains of tubercle bacilli resistant to streptomycin quickly developed. This problem was greatly reduced with the introduction of PAS. Its concomitant use with streptomycin delayed the development and the dominance of resistant organisms. With isoniazid, drug resistance occurs but there is a difference. INH resistant tubercle bacilli, unlike streptomycin resistant organisms (which remain virulent), may lose their virulence for the guinea pig. This loss of virulence has been connected with diminished catalase activity by the tubercle bacillus; that is, they become deficient in their ability to synthetize the enzyme catalase.

Normally, isoniazid sensitive strains, whether pathogenic or nonpathogenic, are catalase positive. Isoniazid sensitive strains which are still catalase positive will usually cause fatal tuberculosis in the guinea pig. On the other hand, the catalase negative organism will not produce lethal disease in the guinea pig or rhesus monkey. The evidence further indicates that catalase deficient strains of tubercle bacilli resistant to INH are attenuated for most human beings. It is thought that initial inadequate dosage of INH may favor the persistence of catalase positive strains.

Metabolism of INH

The metabolism of isoniazid to one or more biologically inactive derivatives has been demonstrated.[13] Significant variation from person to person has been observed. A genetic factor apparently accounts for this difference in INH inactivation. Because of this variation, a few hospitals are presently gauging the dosage of INH after biological assay of the patient's serum and giving the rapid metabolizers higher doses of INH. The correlation of these individual variations in INH metabolism with the patient's response to treatment has not yet been fully demonstrated. Another factor in heightening the level of free serum concentration of INH is the concomitant use of PAS. It is theorized that PAS competes for the acetylation mechanism which serves to inactivate INH as well as PAS and therefore indirectly acts to raise the level of free INH in the serum.

Regardless of the individual variations in isoniazid metabolism, there has been a trend to use higher doses of INH; i.e., more than the customary 5 mg/kg. Berte[14] reports superior results using 10 to 16 mg/kg. of INH along with PAS, 12 gms. daily. He further reports 1.8 per cent toxic reactions to INH and 8.9 per cent manifested toxicity to PAS.

The use of high doses of isoniazid interferes with the formation of pyridoxine (B-6). To combat this potential deficiency, it is customary to give pyridoxine (about 100 mg.) when using more than 400 mg. of isoniazid daily. This supposedly prevents or lessens the frequency of peripheral neuropathy, said to occur in about 2 per cent of patients. McCune and associates have shown that large doses of pyridoxine antagonizes the antituberculosis effect of isoniazid in mice.[15] At present there is speculation that the neuritis preventing effect of pyridoxine administration is simply a reduction of free isoniazid available.

Adrenocortical Steroid Therapy

The steroids, as adjunctive therapy in tuberculosis, are being employed with increasing frequency. This may sound a bit surprising as physicians have been made aware of the hazards of giving these hormones to persons with latent or inactive disease.[16] This is a real danger and all persons requiring prolonged cortico-steroid therapy should have periodic chest films if the tuberculin test is positive. Their use in known disease presents a different situation. It is agreed by many clinicians that tuberculous meningitis is benefited by steroids, particularly if there is spinal block. Also, there are a number of patients with widespread disease, who fail to respond to standard therapy, who appear to be helped by corticosteroids.

The mode of action of the steroids is not fully understood. It is apparently more than simply an anti-inflammatory effect. Weinstein and Koler report a control study where the steroids were employed in all stages of tuberculosis.[17] It was their impression that the hospital stay of such patients was shortened by virtue of accelerated sputum conversion and cavity closure. They used prednisolone for 68 days, averaging about 12 mgs. daily. More controlled studies are needed to clarify the indications for the use of these potent substances, but it appears that steroids can be safely administered to select tuberculous patients. *When used, the patient must be covered by antituberculosis drugs to which the organisms are susceptible.*

Surgery

The indications for surgery in pulmonary tuberculosis are now fairly well defined. This has been the result of a better appreciation of what antimicrobial agents can and cannot do.

Resection is the procedure used in most situations. As to type of resection, there has recently been a shift toward lobectomies and away from segmental and subsegmental resection. Cavitary lesions that fail to close

after a trial of chemotherapy should be resected whenever possible. Small residual closed necrotic foci (usually under 2 cm.) are now seldom removed as they frequently were a few years ago. The present attitude is that long-term drug therapy provides sufficient protection against future reactivation of small residual lesions.

The removal of cavitary foci carries with it slight risk while providing assurance for future stability not otherwise possible. The present operative mortality rate for lobectomy is about 2 per cent, while the morbidity rate is about 10 per cent.[18] Artificial pneumothorax and pneumoperitoneum have been abandoned.[19] A primary thoracoplasty or plombage thoracoplasty is occasionally used instead of resection in those with loss of sensitivity of the organisms to the tuberculosis drugs or because of marked reduction in pulmonary reserve.

The problem of recognizing tuberculous cavities was seemingly solved by the now wide-spread use of chest planigrams. This x-ray technique is essential in the management of tuberculosis; however, intensive chemotherapy has brought a new problem. This is the bullous and cyst-like cavities that follow healing. These blebs may develop either abutting the site of the former cavity or close to it. Also, the original cavity may end as a thin walled bleb-like structure. These post inflammatory changes were noticed before the chemotherapy era, but now are seen more frequently especially since the introduction of isoniazid.

The patient who converts his sputum and has a cavity remaining presents a difficult problem in therapy. A few years ago it was generally thought that such patients should have a resection; now we are not so dogmatic. Some of these cavities will show evidence of open healing on pathologic examination or will turn out to be simply blebs. More often, however, there are residual foci of active disease found that pose a threat for the future and are best removed.

Non-pulmonary Tuberculosis

In general, the drug therapy programs are the same for non-pulmonary as for pulmonary tuberculosis. The management of the former is often easier because there is no problem of cavitation with its hazards of persistent positive sputum and drug resistance.

Glandular tuberculosis is probably the most common extrapulmonary lesion now seen. It is well to stress the use of isoniazid plus a second drug. Further, treatment should be continued for at least a year, regardless of how rapid the glandular swelling subsides. Miliary and meningial tuberculosis respond well in persons over two years of age with at least 70 per cent recovery. Below two years, the response, regardless of the regimen, is poor. A satisfactory drug program is INH 10 mg/kg. daily plus SM intramuscularly daily with or without PAS. Intrathecal streptomycin is not used. An increasing number of physicians are adding the steroids or ACTH. Genito-urinary tuberculosis responds well to INH-PAS given for one year.[21]

Discussion

The treatment of tuberculosis centers around long-term, continuous chemotherapy. The three front rank drugs continue to be isoniazid, streptomycin, and para-aminosalicylic acid with isoniazid the most valuable. Among the second rank drugs are viomycin, cycloserine, pyrazinamide, and oxytetracylines. A number of new and promising drugs are under clinical trial. The adjuvant role of the cortico-steroids appears promising, but their place in treatment is not yet secure.

Most patients undergoing treatment for the first time with early disease will do well on any of several drug combinations. Differences occur only in patients with advanced disease with cavitation. In these patients, the combination of INH and PAS appears to have a slight edge in speed of cavity closure and sputum conversion. Further initial intensive therapy, employing all three drugs including daily streptomycin, probably has a place in the treatment of some patients with extensive disease during the first three months. It is to be noted, however, that triple drug therapy produces more toxicity and does not reduce the problem of drug resistance. In about 10 per cent of such cases, streptomycin toxicity results in its discontinuance.

If cavities are not closed by eight months of chemotherapy, then continued expectant

treatment with the same drugs is unwise and surgical treatment should be employed. If for some reason, surgical treatment cannot be carried out, drug therapy is best continued indefinitely.

Hospital care is superior to home management for the majority of patients. The biggest difficulty under outpatient or home management is the erratic drug therapy that often occurs. A common situation is the stopping of drugs by the patient after three or four months. A patient may experience some intolerance, real or imagined, to a drug. He is feeling fine so he stops one or both drugs. PAS is the drug most frequently discontinued or its dosage reduced to an inadequate level. Ross and associates did a follow-up study of patients admitted to Edinburgh Hospitals in 1953.[22] No relapses occurred in patients with drug sensitive organisms that received 15 months of chemotherapy. Those receiving short interrupted courses had a high relapse rate. A problem common among outpatients is the delay or failure to have needed surgery. Another error has been the long continued use of streptomycin in the presence of cavitation where drug resistance is almost a certainty.

Sir William Osler said, "It is just as important to know what is in a man's head as what is in his chest if you want to predict the outcome of his pulmonary tuberculosis." This is still true. The greatest treatment problem is getting the patient to accept and follow your recommendations. This overshadows the matter of what specific drug program to use or what surgical measure is best. Tolerance and understanding on the part of the physician are necessary to cope with the emotional adjustment many patients find hard to make.[23]

Summary

The basis of the treatment of tuberculosis is the long-term use of anti-tuberculosis drugs. A sheltered environment best provided in a hospital supplements drug therapy. Here the patient should remain at least until a favorable trend has been established. This means a negative sputum and cavity closure, with or without the aid of surgery.

The physician using antituberculosis drugs has a responsibility that must not be undertaken casually. With a cooperative patient and their proper use, complete recovery can be assured; while with their haphazard use, the outcome can readily be one of relapses with persistent civitary disease, drug resistant organisms, and chronic invalidism.

BIBLIOGRAPHY

1. McDermott, Walsh: The enlarging role of the general practitioner in tuberculosis therapy. J. Chronic Dis. 2, 2: 234-238, 1955.

2. Tempel, Carl W., Hughes, Frederic J., Mardis, Richard E., and Towbin, Milton N.: Combined intermittant regimens employing streptomycin and para-aminosalicylic acid in the treatment of pulmonary tuberculosis. Tr. Nat. Tuberc. A. 46: 27-43, 1950.

3. McDermott, Walsh: Isonicotinic acid derivatives in tuberculosis treatment: history of the development of the drugs. Tr. Nat. Tuberc. A. 48: 420-424, 1952.

4. Maher, John R., et al. Studies on the mode of action of isoniazid. Am. Rev. Tuberc. 77: 501-505, 1958.

5. Hobby, Gladys L. and Tulita, Lenert: The in vitro action of the antituberculosis agents against multiplying and non-multiplying cells. Am. Rev. Tuberc. 76: 1031-1048, 1957.

6. Ferebee, Shirley H., Mount, Frank W., Anastasiades, A. A.: Prophylactic effects of isoniazid on primary tuberculosis in children. Am. Rev. Tuberc. 76: 942-963, 1957.

7. Palmer, Carrol E., Shaw, Lawrence W., and Comstock, George W.: Community trials of BCG vaccination. Am. Rev. Tuberc. 77: 877-907, 1958.

8. U. S. Public Health Service Ad Hoc Advisory Committee on BCG. Report of the ad hoc advisory committee on BCG to the Surgeon General of the United States Public Health Service. Am. Rev. Tuberc. 76: 726-731, 1957.

9. Wier, J. A., Taylor, R. L., Weiser, O. L., and Fraser, R. S.: An evaluation of ambulatory vs. non-ambulatory treatment of hospitalized patients with pulmonary tuberculosis. Tr. 15th VA-Armed Forces Conf. on Chemotherapy of Tuberculosis, 1957, p. 38.

10. Rothstein, Emil: The 17th VA-Armed Forces conf. on chemotherapy of tuberculosis. New England J. Med. 258: 1199-1204, 1958.

11. Muschenheim, Carl, Jordahl, Clarence W., Des Prez, Roger M., Deuschle, Kurt, and McDermott, Walsh: Further observations on single drug (isoniazid) therapy in tuberculosis: Significance with respect to selection of companion drugs in initial and subsequent phases of treatment. Tr. 16th VA-Armed Forces Conf. on the Chemotherapy of Tuberculosis, 1958, p. 117.

12. Morrisey, John F. and Ruben, Hugh C.: The detection of hepatic toxicity due to pyrazinamide by means of the determination of serum enzymes. Tr. 17th VA-Armed Forces Conf. on Chemotherapy of Tuberculosis, 1958, p. 59.

13. Mitchell, Roger S., Riemensnider, Dick K., Harsch, John R., and Bell, J. Carroll. New information on the clinical implications of individual variations in the metabolic handling of antituberculosis drugs, particularly isoniazid. Tr. 17th Conf. on Chemotherapy of Tuberculosis, 1958, pp. 77-85.

14. Berte, Stephen J., et al.: An evaluation of chemotherapy in pulmonary tuberculosis. Part I and Part II. Am. Rev. Tuberc. 78: 773-784, 1958.

15. McCune, Robert, Deuschle, Kurt, and McDermott, Walsh: The delayed appearance of isoniazid antagonism by pyridoxine in vivo. Am. Rev. Tuberc. 76: 110-115, 1957.

16. Shubin, Harry, Lambert, Robert, and Heiken, Charles A.: The place of steroids in pulmonary disease. Dis. Chest 24: 138-149, 1958.

17. Weinstein, Haskell J., and Koler, John J.: Adrenocorticosteroids in the treatment of tuberculosis. New England J. Med. 260: 412-417, 1959.

18. Steele, John D.: The indications for surgery in pulmonary tuberculosis. Ann. Int. Med. 50: 51-61, 1959.

19. Roque, F. T.: Temporary collapse in the treatment of pulmonary tuberculosis. Dis. Chest 34: 404-412, 1958.

20. Weiner, A. A. and Boldowsky, V.: The formation of bullous cavities following antimicrobial therapy for pulmonary tuberculosis. Sea View Hosp. Bull. 16: 170-180, 1957.

21. Lattimer, John K. Wechsler, Herman, Almodovar, Alfred, and Boyes, Truman: Chemotherapy of kidney tuberculosis. Tr. 16th VA-Armed Forces Conf. on Chemotherapy of Tuberculosis, 1958, p. 154.

22. Ross, J. D., Horne, N. W., Grant, W. B., and Crofton: Hospital treatment of pulmonary tuberculosis: Follow-up study of patients admitted to Edinburgh Hospitals in 1953. Brit. M. J. 1: 237-242, 1958.

23. Hammarsten, James F. and Wolf, Stewart. The role of the emotions in respiratory disease. M. Clin. North America 43: 113-126, 1958.

430 N.W. 12th, Oklahoma City, Oklahoma

Basic Science Brief:

The Androgens

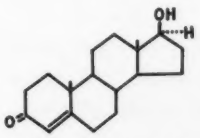
R. W. PAYNE, M.D.

Richard W. Payne, M.D., graduated from the University of Oklahoma School of Medicine in 1943. He is now Associate Professor of Pharmacology and Instructor in Medicine at the same school.

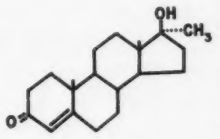
BIOLOGICALLY active androgenic extracts were first prepared from bull testes by Doctor F. C. Koch (1929). An androgenic material was extracted from human male urine by Butenandt (1931) who, within the next year, determined its structure and assigned the name "androsterone." This compound was synthesized from cholesterol by Ruzicka in 1934. Testosterone was crystallized from extracts of bull testes by Laqueur in 1935 and was synthesized by Ruzicka during the same year.

Testosterone, the predominant male sex hormone, is produced by the Leydig cells of the testes upon stimulation by the interstitial cell stimulating hormone (ICSH) of the anterior pituitary gland. Androgenic compounds are also produced by the adrenal cortex and under some circumstances by the hilar cells of the ovary.

The androgens are derivatives of the cyclopentanophenanthrene (steroid) nucleus. They are generally poorly soluble in water but more soluble in oils and other organic solvents.

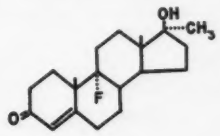


Testosterone, the androgen normally secreted by the testis, is produced synthetically from cholesterol. Intensification and prolongation of testosterone action can be achieved with various esters including the propionate, cyclopentyl propionate, (Depo Testosterone®), phenyl acetate, isobutyrate and enanthate (Delatestryl®).

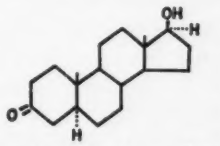


Methyltestosterone is an orally effective derivative of testosterone.

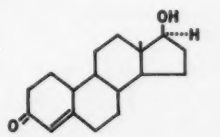
Greatly enhanced androgenic effect by the oral route is exhibited by Fluoxymesterone (1956) Halotestin®) (Ultandren®)



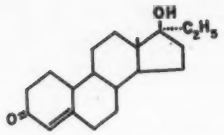
In the search for compounds which might exert more anabolic than androgenic effect several modifications of the androgen nucleus have been introduced:



Methylandrostendiol exhibits about 1/5 the androgenic potency of testosterone. Stanolone (Neodrol®) is the most potent androgen of the androstane series.



19-nortestosterone, a relatively weak androgen, appears to exert a favorable anabolic/androgenic ratio. The phenyl-propionate ester (Durabolin®) exerts a prolonged effect.

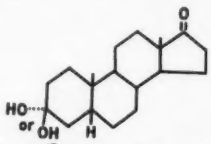


Norethandrolone (Nilevar®) (1956) is an orally effective weak androgen with somewhat enhanced anabolic and progestational effects.

MODE OF ADMINISTRATION:

Crystalline testosterone may be administered parenterally as an aqueous suspension, implanted as compressed tablets (pellets), or as buccal tablets for transmucosal absorption. The esters of testosterone are administered as oily solutions or aqueous suspensions. Methyl testosterone is effective when administered by either the oral or buccal routes. Fluoxymesterone and Nilevar® are fully effective by the oral route.

compound also is derived from androgens produced by the adrenal cortex. Its 3β isomer (isoandrosterone) is only weakly androgenic.



The etiocholanolones (3α and 3β) are biologically inactive.

Approximately $\frac{2}{3}$ of excreted 17-ketosteriods are of adrenal origin. These include androstane and androstene diones and dihydroisoandrosterone (DHIA).

Esterification of testosterone serves to slow its absorption and degradation in the body.

Methyl testosterone is not excreted as a 17-ketosteroid but is excreted to some extent in its original form.

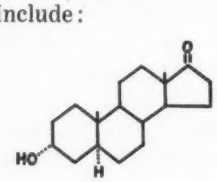
COMPARISON OF ANDROGENIC STEROIDS

Androgen	Route of Administration	Dose	Relative Effectiveness	Duration of Action	Vehicle
Testosterone Propionate	I.M.	50 mg.	100*	3-4 days	Oil
Testosterone Propionate	Buccal	50 mg.	50	1 day	Propylene Glycol
Crys. Testosterone	S.C. Implantation	600 mg.	5	6-8 mo.	Compressed Tablet
Crys. Testosterone	Buccal	50 mg.	50	1 day	Compressed Tablet
Testosterone Cyclopentylpropionate	I.M.	100 mg.	25	2 wks.	Oil
Testosterone Enanthate	I.M.	100 mg.	25	2 wks.	Oil
Fluoxymesterone	Oral	10 mg.	100	1 day	Compressed Tablet
Methyltestosterone	Buccal	50 mg.	100	1 day	Propylene Glycol
Methyltestosterone	Oral	50 mg.	50	1 day	Compressed Tablet
Nilevar®**	Oral	50 mg.	8	1 day	Compressed Tablet

*—Arbitrary figures comparing androgenic potency to testosterone propionate by injection
**—Anabolic effect equal to testosterone propionate

INTERMEDIARY METABOLISM:

Testosterone and its esters are destroyed by the body largely by the liver to the extent that only about 40% of the administered dose can be accounted for in the urine on the basis of readily identifiable metabolites. These excretion products, known as neutral 17-ketosteroids, are largely excreted as conjugated products. These excretion forms include:



Androsterone, the most abundant metabolite, exhibits about 1/10 the activity of testosterone. This

Transmucosal absorption of testosterone and methyl testosterone leads to enhanced effect over the oral route largely due to delayed passage through the liver. Estrogenic excretion products of 19-nortestosterone have been identified.

The relative contribution of the adrenal cortex and the testis to neutral 17-ketosteroid excretion is outlined by the following circumstances:

	Normal	Castrate	Addisons Disease
Adult Male	14*	9	5
Adult Female	9	9	0

*Urinary excretion 17-KS. (mg./24 hrs.)

BIOLOGIC EFFECTS:

Anabolic Properties:

Compounds of the androgenic series stimulate cell growth and aid in general protein anabolism. They cause retention of nitrogen, sodium, potassium, chloride, phosphorus and calcium. Creatine storage in muscle is promoted by testosterone but not by methyltestosterone, fluoxymesterone or norethandrolone. An increase in serum cholesterol commonly follows administration of drugs of the androgen series.

Androgenic Properties:

Androgens provide for development and maintenance of secondary masculine sex characteristics, i.e., body hair growth, deepened pitch of the voice, increased sebaceous gland secretions, development of male genitalia and masculine aggressiveness. The administration of these compounds can frequently be shown to produce alterations in mood which may include euphoria, increased appetite as well as the sensations of increased strength and reduced fatigability in both sexes. The latter psychic sequelae are generally in excess of demonstrable anabolic effects.

Atrophy of the testes and suppression of ovulation follow administration of the androgens.

In small doses the androgens produce a progesterone-like effect in maintaining the estrogenized (proliferative) uterine endometrium but do not induce the slight rise in body temperature which is a characteristic of progesterone effect. Inhibition of intermittent uterine contractions may also follow administration of these agents. Large doses of androgens lead to an anti-estrogenic effect on the endometrium and atrophy of the vaginal mucosa.

TOXICITY:

Side effects of androgen therapy are largely the result of undue physiologic effects of these agents. Excessive doses in the female (more than 200 mg. of testosterone propionate monthly) may lead to oily skin, acne, thinning of the scalp hair, beard growth, enlargement of the clitoris, cessation of menses, increased libido and other manifestations of masculinization. In the male, gynecomastia (especially with methyl testosterone), decreased spermatogenesis, and priapism may occur. In both sexes overenthusiastic use of androgens may lead to hypercalcemia (particularly if the patient is immobilized), hyperlipemia, diminution of cardiac reserve with cardiac decompensation, hypertrophy of the kidney with oliguria, and premature epiphyseal closure. Anxiety symptoms may be induced in both sexes and undue activity in the aged individual may be provoked.

Methyltestosterone and norethandrolone (Nilevar) in relatively large doses for prolonged periods may provoke jaundice. This jaundice appears to be due largely to bile stasis in the liver. Increased bromsulphalein retention occurs in a high percentage of patients receiving Nilevar.

CONTRAINDICATIONS:

The use of androgens is inadvisable in the presence of carcinoma of the prostate, benign prostatic hypertrophy, congestive heart failure or renal failure. Methyltestosterone and Nilevar are contraindicated in the presence of liver disease.

THERAPEUTIC INDICATIONS:

The dosage of androgens is generally governed by the attainment of desired therapeutic effects with a minimum of side effect. There is considerable variation among individuals in their sensitivity to these hormones and thus the dosage must be titered with these factors in mind.

Males with deficient gonadal secretions are generally particularly sensitive to androgenic therapy. Treatment of these individuals is begun cautiously at the time of puberty (9½ to 11 yrs.) to the purpose of mimicking puberal changes. Doses of methyltestosterone in the order of 5 mg. daily by the oral route (or comparable androgen) are generally adequate for the development of secondary sexual characteristics. Once the male characteristics are fully developed the withdrawal of androgens is accompanied by relatively minor decline in masculine conformation. Under such circumstances (secondary hypogonadism) a low androgen titer

may be manifested by such evidence as soft "pasty" skin which doesn't tan well and shrinking with depigmentation of the scrotum; the timbre of the voice and size of the genitalia do not regress. The proper dose of androgen for these individuals can be gauged upon the basis of correction of the above manifestations, as well as other evidences of virilization, and increase in libido and potentia. Adult hypogonadal individuals are ordinarily maintained on androgenic doses comparable to testosterone propionate 25 mg. I.M., twice weekly. The hypothetical "male climacteric" as manifested by mental and emotional symptoms, waning libido and potentia, fatigability, loss of ambition, lassitude and vasomotor instability may occasionally be benefited by comparatively large doses of androgens (T.P. 25 mg. I.M. 2-3 x weekly).

A limited growth increment may occur in various types of dwarfism in both sexes following administration of androgens; however, the use of these agents in the treatment of delayed adolescence and cryptorchidism is unwarranted. Premature epiphyseal closure may follow over-exuberant use of androgens in younger individuals.

Oligospermia may be temporarily corrected following the withdrawal of large doses of androgens. To this end testosterone propionate 150 mg. is administered intramuscularly at weekly intervals (or equivalent) for 4 doses; increased spermatogenesis occurs within 4-6 weeks after the last injection.

Dysmenorrhea and premenstrual tension may be reduced by administration of androgen during the last two weeks of the menstrual cycle (testosterone propionate 10-25 mg. I.M. twice weekly).

Painful post partum uterine contractions may be reduced by small doses of androgens begun at the conclusion of labor; larger doses may be employed at this time to suppress lactation or to reduce breast engorgement.

The painful masses of chronic cystic mastitis may subside under treatment with androgens. Functional uterine bleeding may be temporarily stopped with androgens in a manner similar to progesterone.

Temporary symptomatic relief in carcinoma of the breast of the post menopausal castrate female may be afforded by androgens in relatively large doses.

Androgens (frequently combined with small doses of estrogens) are frequently used in the treatment of osteoporosis, osteomalacia, and various of the arthritides. In these conditions the improvement which follows is largely of a symptomatic nature.

The catabolic effects of immobilization, Addison's disease, Cushing's syndrome and following prolonged administration of glucocorticoids may, at least theoretically, be somewhat mitigated by androgen therapy.

Miscellaneous uses of androgens have included the treatment of enuresis, uremia, anemia, anorexia nervosa, frigidity in females, loss of libido in the male, pruritis, endometriosis and prematurity in infants.

Sample Prescription: For the treatment of secondary hypogonadism in the adult male.

Name ..... Date .....

Address .....

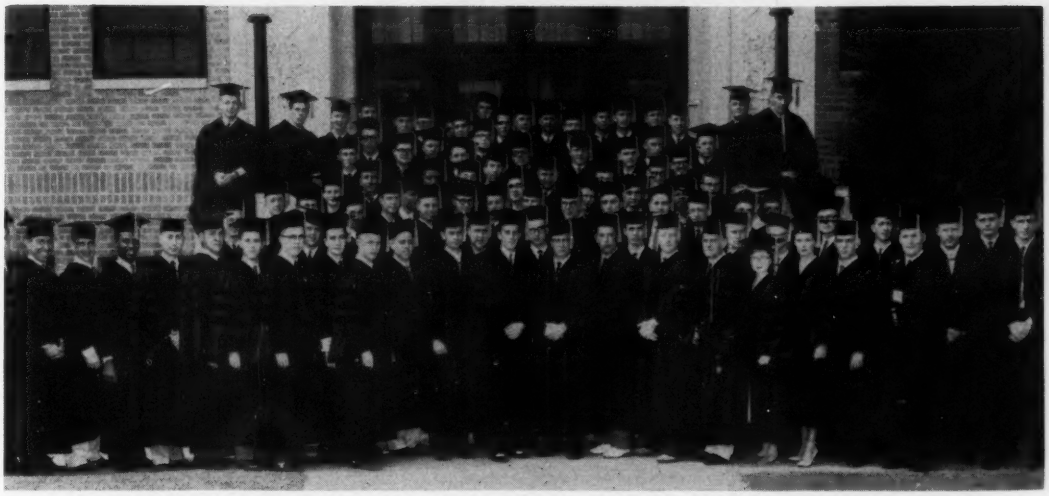
℞

Halotestin	005
Tabs. #50	
Sig: Tabs 1 daily.	

.....M.D.

800 N.E. 13th, Oklahoma City, Oklahoma

OU School of Medicine Awards 92 Degrees



Class of 1959—University of Oklahoma School of Medicine.

The University of Oklahoma School of Medicine awarded M.D. degrees to 92 members of the Class of '59 at commencement ceremonies held May 24 at Holmberg Hall on the Norman campus.

Degrees were conferred by George L. Cross, Ph.D., University president, and Mark R. Everett, Ph.D., D.Sc., Director and Dean of the Medical Center.

Fifty-five of the graduates will intern in Oklahoma hospitals. New M.D.s, their hometowns and internship appointments for 1959-60 are:

At University of Oklahoma Hospitals—Thomas B. Acers, M.D., Charles R. Key, M.D., Frederick Mannerberg, M.D., Lynn L. Myers, M.D., and Edward E. Smith, M.D., all of Oklahoma City; Roy Dixie Baines, M.D., and Joe T. Bledsoe, M.D., Tuttle; Jerry B. Cotner, M.D., Hartshorne; Nathan A. Guerkink, M.D., Ardmore; Jess Hensley, M.D., Chelsea; Douglas C. Wilkerson, M.D., Okeene; Donald R. Pfeifer, M.D., Tulsa; Nancy Rabon, M.D., Copan, and Lloyd E. Rader, Jr., M.D., Binger.

At Wesley Hospital, Oklahoma City—Marcus W. Adams, Jr., M.D., Ray Motley, M.D., and James A. Kunkel, M.D., all of Oklahoma City; Richard G. Dotter, M.D., Alva; Lycurgus O. Laughlin, M.D., Stillwater; Horace D. Townsend, M.D., Tulsa, and Joan L. Webb, M.D., Pawhuska.

At Mercy Hospital, Oklahoma City—Richard K. Alexander, M.D., and Doyle Johnson, M.D., Muskogee; Merle D. Carter, M.D., Tulsa; Clint E. Chambers, M.D., Chickasha; John R. Trammell, M.D., Hollis; Billy D. Dotter, M.D., Alva, and Felix R. Kay, M.D., Big Cabin.

At Veterans Administration Hospital, Oklahoma City—Leroy M. Milton, M.D., Shawnee.

At St. Anthony Hospital, Oklahoma City—Robert K. Borron, M.D., Bethany; Edward Esparza, M.D., Stillwater; Thomas H. Fraley, Jr., M.D., Hominy; Billy J. Matter, M.D., Hooker; John H. Gardner, M.D., Guthrie; Phillip L. Shepherd, M.D., Wewoka; Carl R. Smith, M.D., Tulsa; Richard A. Storts, M.D., Norman, and Harold D. Wilkins, M.D., Elk City.

Assignments in Tulsa:

At. St. John's—Robert G. Bissell, M.D., Norman; John C. Day, M.D., Heavener; Damon G. Gregg, M.D., Beaver; George H. Ishler, M.D., Chickasha; James R. Kay, M.D., Oklahoma City; Bonnie G. Miller, M.D., Hardesty; Noel E. Miller, M.D., Yale; Thomas J. Smith, M.D., Guymon; and Thomas M. Story, M.D., Edmond.

At Hillcrest Medical Center—Charles A.

Clough, M.D., Norman; Donald D. Collins, M.D., Vinita; Max A. Deardorff, M.D., Tulsa; William E. Ellifrit, M.D., Ponca City; Robert R. Hillis, M.D., Lawton; Richard D. King, M.D., Duncan; Jesse S. Little, M.D., Minco; and Donald L. Randall, M.D., Pryor.

Interning in medical centers out of the state are:

University of California hospitals, Los Angeles—Byron J. Bailey, M.D., Oklahoma City. Tripler Army hospital, Honolulu, Hawaii—John W. Barnhill, M.D., Oklahoma City. University of Texas Medical Branch hospital, Galveston—James E. Berry, M.D., Oklahoma City; James R. Carroll, M.D., Tulsa; Charles K. Casteel, M.D., Atoka; William S. Chambless, M.D., Chickasha; and David D. Rose, M.D., Oklahoma City.

Walter Reed hospital, USAF, Washington, D.C.—Horace J. Brown, M.D., Norman, and James W. Dyer, M.D., Miami, Okla. U.S. Naval hospital, Oakland, Calif.—John K. Chestnut, M.D., Duncan, and James D. Long, M.D., Enid. Salt Lake County General, Salt Lake City, Utah—Robert S. Cloud, M.D., Oklahoma City. Cook County hospital, Chicago—Richard A. Conley, M.D., Kingfisher. San Francisco hospital, San Francisco—Robert G. Davis, M.D., Tulsa.

Highland Alameda general, Oakland, Calif. —Robert H. Drewry, M.D., Lawton, and Charles L. Ritchey, Jr., M.D., Alva. Orange Memorial hospital, Orlando, Fla.—Emmett B. Ferguson, Jr., M.D., Hinton, and Kenneth D. Kiester, Jr., M.D., Duncan. Gorgas hospital, Canal Zone—Robert G. Franz, M.D., Enid, and Charles W. Simcoe, M.D., Stillwater. Bryan Memorial, Lincoln, Neb. —Victor E. Hanson, M.D., Pond Creek.

University of Kansas hospital, Kansas City—Paul C. Houk, M.D., Fairview. Washington Hospital center, Washington, D.C.—Jerry King, M.D., Barnsdall. St. Luke's hospital, Cleveland, Ohio—Irving Klein, M.D., Oklahoma City. St. Luke's, San Fransico—Jo Ellen Latta, M.D., Tulsa. Hurley hospital, Flint, Mich.—Billie Lewis, M.D., El Reno, and Vivian M. Lewis, M.D., Oklahoma City.

Bellevue Hospital center (2nd Medical division), New York City—Eugene Morkin, Jr., M.D., Oklahoma City. Johns Hopkins, Baltimore, Md.—Wiley H. Mosley, M.D., Oklahoma City, and Richard F. Tenney, M.D., Tulsa.

Mary Imogene Bassett, Cooperstown, N.Y. —Richard H. Runser, M.D., Oklahoma City. U.S. Naval, Camp Pendleton, Oceanside, Calif.—Ralph G. Sablan, M.D., Sinajana, Guam. Baylor University, Houston, Texas—Robert L. Stockton, M.D., Bethany. Sacred Heart General, Eugene, Ore.—Jimmy R. Strange, M.D., McAlester. D.C. General hospital, Washington. D.C.—John L. Townsend, M.D., Oklahoma City. U. S. Public Health Service, New Orleans, La.—Don R. Vesley, M.D., Tahlequah. St. Francis, Honolulu, Hawaii—Betty L. Whitener, M.D., Tulsa.

Two New Faculty Appointments

Hugh Francis Maguire, D.D.S., clinical assistant in surgery and Mary N. Sloan, M.S.S., instructor in psychiatric social work, are new members of the faculty of the University of Oklahoma School of Medicine.

MAGURIE

Doctor Maguire, born in Oklahoma City, received his B.S. in bacteriology at the University of Oklahoma in 1950 and his D.D.S. degree as Kansas City Western Dental College in 1954.

Mrs. Sloan has been on the Medical staff since 1954. Serving four years as a medical social worker in the Department of Pediatrics, she transferred to the Department of Psychiatry December 1, and received her faculty appointment May 13.

SLOAN

A native of New Jersey, she was graduated from the University of North Carolina with a B.A. in sociology, attended the University of North Carolina School of Social Work and received her master's in social work at Smith College School for Social Work in 1950.

Underweight Children Gain and Retain Weight with Nilevar®

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

---

*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

PRESIDENT'S LETTER

It Is Later Than We Thought

We received telegraphic notice June 25, 1959, that hearings on the Forand Bill, H.R. 4700, are scheduled to begin the week of July 13. It had been hoped that any action by the Congress would be delayed until factual studies could be made of the problem.

If I were asked, I would be tempted to say that the advancement of the hearings was motivated by political considerations, rather than any sudden deterioration of the national health.

The resources of the Oklahoma State Medical Association are being mobilized to define the problem to the individual members, the public, and members of Congress.

This will be a challenge to the Federal Government Relations Committee, and a test of the sense of responsibility of the individual members of O.S.M.A.

The active and unwavering cooperation of all is indispensable at this time.

Alfred T. Baker M.D.

ALFRED T. BAKER, M.D.
President

Special Article

Report of the Sub-Committee on Research of the Committee on Aging of the Oklahoma State Medical Association.

GERIATRIC RESEARCH in OKLAHOMA

LEONARD P. ELIEL, M.D.

THE DEVELOPMENT of means for the achievement and maintenance of physical, mental and social health and well-being should be the goal of research in the field of aging as it is in other fields.

The sub-committee believes that its principal function is to point out those areas in which the Medical Association can constructively assist in research in achieving its goals.

The resources available to organized medicine are at present too limited to provide anything but token financial support. Physicians as a group can, however, influence importantly policies, attitudes, and practices of private, state, and federal organizations in relation to research and education in this field. The Medical Association can also play an important part in the achievement of the goals by informing the public of the needs and accomplishments of research into problems of aging.

Problems in some areas have been well defined, are handsomely supported, and have yielded significantly to intensive investigation in recent years (cardiovascular and neoplastic disease). Research in other areas has been hampered by lack of interest, imaginative ideas, suitable techniques, well-trained research personnel, and funds (social problems, psychiatric disease, and basic studies of tissue changes in the aging process).

The "feast or famine" aspect of research support for problems of aging is illustrated by the distribution of funds into various categories within the University of Oklahoma Medical Center (the figures are approximate and do not include funds in the Veterans Administration Hospital research program, but do include Oklahoma Medical Research Foundation funds).

It is evident that the scope and nature of many of the problems in the field have

TABLE I

DISTRIBUTION OF FUNDS IN THE FIELD OF AGING

in the

UNIVERSITY OF OKLAHOMA MEDICAL CENTER

(1958-59)

1.	Cardiovascular Disease*	$275,538
2.	Cancer	255,519
3.	Teaching**	78,776
4.	Basic	36,248
5.	Psychiatry	17,250
6.	Arthritis	17,000
7.	Diabetes*	5,251

*Extensive studies of lipid and carbohydrate metabolism in cardiovascular disease can also be considered as bearing on the problem of diabetes.

**This category obviously includes teaching in other areas but would require considerable investigation for an accurate breakdown.

scarcely been defined or formulated, making it impossible to determine, without experience and investigation, what kind of work is most needed or where emphasis should be placed in terms of financial support.

Exploration of the potential role of teaching and research institutions, clinics, and physicians in the investigation, care, and prevention of geriatric problems is an urgent necessity. A gratifying step in this direction is the development of a geriatric clinic in the University Hospital. This clinic will acquire an experience with geriatric problems which should make it possible to: (1) determine their nature and magnitude, (2) suggest techniques for conferring adequate attention on them in the clinic setting, (3) give students, house staff, and practicing physicians experience in dealing with them, and (4) point out areas where exploration of preventive measures and research are needed. The Medical Association should recognize and endorse this constructive development, encourage and assist in communication of the clinic's findings to the profession and consider, if needed, financial support of a clinic or other similar clinics should it prove successful and warrant continuation of an expanded or more widespread basis.

A vital role that the Association can play is in encouraging interest in the field and in dissemination of information pertaining to it. Several suggested means of doing so might be as follows: (1) annual prizes could be offered to medical students and house officers for essays or reports in the field which would be published by the State Journal, (2) a fellowship in geriatric studies might be supported by the Association in the School of Medicine, this fellow to work closely with the geriatric clinic, (3) one or more student fellowships might be offered for research in the fields of aging during a student's elective periods or time off, (4) the Association can urge that adequate attention be devoted to problems of aging in the curriculum and in post-graduate courses, (5) the Association should encourage the publication and review of results of research, both here and elsewhere, in the field of aging, and (6) the Association can assemble and distribute or publish information relative to sources of support for research into problems of aging.

Finally, the subcommittee feels that the interest of research into aging would best be served through an endorsement by the Medical Association of continued and increasing private and federal research support, particularly for relatively under-developed areas but most particularly for the training of capable research personnel in the setting of research and teaching institutions.

Medical News

Program Is Outlined for AHA Scientific Sessions

Early registration is recommended for those planning to attend the 32nd annual Scientific Sessions of the American Heart Association to be held at the Trade and Convention Center in Philadelphia, October 23-25. Physicians who register by mail will receive a complimentary advance copy of the program booklet containing abstracts of the proceedings. This program will cost $2.00 at the meeting. Forms for registering and for reserving accommodations are now available from the Association, 44 East 23rd Street, New York 10, N. Y.

Following is a tentative outline of the Scientific Sessions program:

Friday, October 23:

A morning session on clinical cardiology will be devoted to a symposium on "Regulatory Mechanisms of the Cardiovascular System." Simultaneous morning sessions are scheduled on rheumatic fever, congenital heart disease and circulation. The afternoon program includes: presentation of papers of general interest in clinical cardiology; the Lewis A. Conner Memorial Lecture, to be given by Doctor Lewis N. Katz, Director, Cardiovascular Department, Medical Research Institute, Michael Reese Hospital, Chicago; and a session on cardiovascular surgery.

Saturday, October 24:

A morning session on clinical cardiology will consist of two symposia: "Recent Developments in Diagnostic Techniques" and "Open Heart Surgery in Acquired Valvular Disease." Concurrently, a morning session will be held on high blood pressure research. Scheduled during the afternoon are: presentation of the Albert Lasker Award; the George E. Brown Memorial Lecture, by Doctor Ludwig W. Eichna, Professor of Medicine, New York University College of Medicine; a symposium on "Congestive Heart Failure," including a panel on "Treatment of Congestive Heart Failure" and a presentation on "Life After Heart Failure"; a session on basic science; a session on cardiovascular surgery.

Sunday, October 25:

Included in the morning sessions are a panel on "Conflicting Concepts of Atherogenesis" and a concurrent session on "Instrumental Methods in Cardiovascular Research." In addition to a panel on "Cardiac Resuscitation," to be conducted jointly with the American College of Cardiology during the afternoon, a concurrent session will be devoted to arteriosclerosis. The Association's Annual Dinner is scheduled for Sunday evening.

The Annual Meeting of the Association's Assembly, which will review national policies and activities and elect officers and Board members, will be held on Monday and Tuesday, October 26-27 at the Bellevue-Stratford Hotel.

Colorado Hosts Course In Athletic Injuries

The University of Colorado's Third Annual Postgraduate Course on the Prevention and Treatment of Athletic Injuries will be held at the medical center in Denver on August 10, 11 and 12. Participating physicians will receive 21 hours AAGP credit (category 1) for attending the meeting, which is sponsored by the Division of Orthopedic Surgery and is designed as a refresher course for those serving as team physicians.

In addition to the scientific program, a number of social events are planned, including a Central City play and a banquet where films of the 1956 Winter Olympics will be shown.

Tuition for the course is $40.00. Other information may be obtained by writing to the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Ave., Denver 20, Colorado.

Nine House Staff Physicians Receive Awards

Newly-established award for the most outstanding paper read at the annual meeting of Oklahoma Association of House Staff Physicians went to Gunnar Sevelius, M.D., left. John B. Saunders, president, Oklahoma City chapter, Medical Service Society of America, awards the rotating plaque which will remain in the Oklahoma City Veterans hospital until next year's winner is named.

Nine interns and residents training at six Oklahoma hospitals received awards for outstanding research and clinical papers presented at the fifth annual meeting of the Oklahoma Association of House Staff Physicians May 22.

Twenty-four scientific papers were selected for presentation at the one-day session at the Oklahoma City Veterans Administration Hospital.

Doctor Gunnar Sevelius, resident at Veterans Hospital, received a plaque from the Oklahoma City chapter, Medical Service Society of America, for the best paper in all categories, a report on "Coronary Blood Flow Determined by a Radioactive Surface Counting Technique."

Doctor Sevelius and Doctor C. A. Grimm, resident at University, won monetary prizes from Oklahoma State Radiological society for the best papers dealing with radiology.

The Medical Service Society also made cash awards for the top papers in: basic science, Doctor Robert M. Fagella, resident

Edward N. Farris, M.D., presents American College of Surgeons "best paper pertaining to surgery" awards to (left to right) David D. Snyder, M.D., Jack Stephenson, M.D., Norman A. Cotner, M.D., Harold W. Calhoon, M.D., John Kyriacopculos, M.D., and C. A. Grimm, M.D.

Winners of top papers in three categories were Robert M. Fagella, M.D., left, in basic science, David D. Snyder, M.D., second from right, in surgery, and James W. Hampton, M.D., right, in medicine. John B. Saunders, second from left, made the awards for the Medical Service Society.

at University; surgery, Doctor David D. Snyder, resident at Veterans; medicine, Doctor James W. Hampton, resident at University.

First recipient of the Oklahoma chapter, American Academy of General Practice award for the best paper read by an intern was Doctor Norman A. Cotner, intern at Mercy Hospital, Oklahoma City.

Winners of the annual awards offered by the Oklahoma chapter, American College of Surgeons, for the six best papers in the field of surgery were: Doctor Cotner, Doctor Grimm, Doctor Snyder, Doctor John D. Kyriacopoulos, resident at University, Doctor Harold W. Calhoon, intern at Hillcrest Medical Center, Tulsa, and Doctor Jack Stephenson, resident at St. Anthony Hospital, Oklahoma City.

Doctor Earl Ginn, program chairman this year, was elected association chairman, succeeding Doctor James E. Webb, resident at University. Doctor Ginn is a resident at Veterans and was a 1958 award winner.

Association members also named Doctor Frank Howard, resident at Veterans, 1960 program chairman; Doctor William B. Shelton, Jr., intern at University, secretary-treasurer; and Doctor Howard Keith, resident at University, social chairman.

Oklahoma State Radiological society's cash award for a scientific report in the field of radiology was split between Gunnar Sevelius, M.D., left and C. A. Grimm, M.D., right. Peter E. Russo, M.D., center, made the presentation.

Norman A. Cotner, M.D., left, receives the Oklahoma chapter, American Academy of General Practice citation for the best paper presented by an intern. Making the presentation is Arnold G. Nelson, M.D.

Medicare Clarifies Policies on Malignancies

In a recent communication from the Office of Dependents' Medical Care, the increasing case load involving malignancy was discussed and the policies clarified as to the eligibility requirements for such cases.

The ODMC has taken the position that the patient with a suspected and/or proven malignancy is acutely ill and qualifies for care under the program. It is further recognized by the Medicare authorities that immediate hospitalization is necessary despite absence of readily identifiable signs and symptoms. They also explained that such cases will be accepted for payment provided the patient otherwise qualifies (Medicare Permit is required where patient resides with serviceman) and where the physician certifies that the procedure was not "plannable."

Biopsies

Biopsies performed on patients formally admitted to the hospital are payable provided the physician indicates the need for hospitalization and states that the biopsy was required to properly manage the suspected, or proven, malignancy which, in his opinion, constituted an acute condition. In instances where a Medicare Permit is required for the original admission, an additional permit will not be required for a subsequent readmission for surgery based upon a positive biopsy report.

X-ray Therapy

Under certain circumstances the patient, in the opinion of the physician should receive x-ray, radium or radioisotope therapy rather than surgery. If the patient is otherwise eligible, and if such therapy is prescribed or initiated during a period of hospitalization, such care is compensable. Therapy may be continued on an out-patient basis if prescribed or initiated during hospitalization.

Pamphlet on Mis-Use of Plastic Bags Available

Physicians may want to order complimentary copies of a new pamphlet on the use and mis-use of plastic film for distribution through their waiting rooms. The recent increase in infant and child fatalities attributed to accidental suffocation involving various forms of thin plastic flims, such as garment bags, has prompted the Society of the Plastics Industries to prepare a pamphlet on the subject for the benefit of parents and others concerned with the care of children.

According to James L. Goddard, M.D., Chief, Accident Prevention Program, Department of Health, Education and Welfare, nearly sixty such deaths have been reported in the past two years. Thirty-five deaths have occurred since January 1, 1959, which points up the accelerated incident rate of mis-use of a useful product.

Cooperating with the plastics group in the preparation of the pamphlet were: The American Academy of Pediatrics, the AAGP, the National Institute of Dry Cleaning, the National Safety Council and the Public Health Service of the Department of HEW.

Forest R. Brown, M.D., Director of the Division of Chronic Disease Control, State Department of Health, 3400 North Eastern, Oklahoma City, has a limited supply of the pamphlets to distribute to physicians on request. The educational piece may also be obtained in quantity from the Society of Plastic Industries, Inc., 250 Park Avenue, New York 17, New York.

Oklahomans to Participate In National Conference

The Oklahoma State Medical Association's Associate Executive Secretary, Mr. Don Blair, and the Executive Secretary of the Tulsa County Medical Society, Mr. Jack Spears, have been invited to appear on the program of the Medical Society Executives Association meeting in Chicago, August 19.

Two Enid Doctors Differ on Merits of Service Contract

The Editor
Journal, Oklahoma State
Medical Association
Oklahoma City, Oklahoma

Dear Sir:

For the past several months this writer has given much thought to the current controversial question of Full Coverage or Service Plan Medical Insurance. As many of you know, Oklahoma Blue Cross-Blue Shield has been selling such a plan in Garfield County. Briefly the plan guarantees to the insured, full coverage on medical, surgical and hospital services, if a resident of Garfield County and under medical care in Garfield County. In this letter I have listed a few of the reasons why such a program, Full Coverage Medical Insurance, is not right, is not wanted, is not beneficial to patient or doctor, and is the next step to socialized medicine. I write with deepest sincerity and I hope that I offend no one with my presentation.

The "Public Demand" For A Service Program Is The Planned Ice Program Of A Few

At the initial introduction of the "Doctor's Plan" in Garfield County, Blue officials put much emphasis on increased collections to the participating physicians should such a program be accepted. Later, the program was presented as a means to curtail the fee hiker and to eliminate unreasonable medical-surgical fees. The Blue officials cited the many complaints of indemnity customers as an indication of public demand for a Service Program. We are well aware of customer complaints, fee hikers on the insured and unreasonable medical fees. From my own experience I can't help but feel that the complainers are but a small minority in the overall Indemnity Program. The "Doctor's Plan," that this minority demands, cannot eliminate fee hikers or unreasonable medical fees. These guilty culprits wouldn't participate in a Service Program, so why must we remaining physicians sacrifice our freedom of levying fees for a lost cause? Let the Grievance Committees, public sentiment and the courts handle these abuses.

We were told by Blue officials that 75% of our nation's doctors are under some type of a Service Program. We were also told that a successful Service Program was the only prevention to Government medicine. If 75% of our doctors are under a Service Program and today we are closer to Socialized Medicine than at any other time I cannot accept the statement by Blue officials that a Full Coverage Program is the only prevention to Socialized Medicine.

Although Service Plans have been accepted by many State Medical Associations, they have likewise been rejected. Our own Tulsa County Medical Society rejected such a program. In 1946-1947 a Service Plan program failed in Woods County. I am curious to know why the Service Program has not been presented to our State Medical House of Delegates. I am curious why the Service Program has been confined to Garfield County. In states where a Service Plan is in effect there has been a constant wave of rate increases and requests for rate increases, some requests up to 50%. A Full Coverage Plan in New York City was given a rate increase, after a two day court battle, to offset the Service Plan loss of $75,000.00 daily. Michigan clamped a ceiling on Blue payments to hospitals for the remainder of 1958 to forestall rate increases. During the past three years there has been a gradual increase in the number of Blue Plans that have a total expense in excess of annual subscriber income and likewise an increasing number that have experienced a deficit in net income. After six months under the Full Coverage Plan in Garfield County there

has been an increase in total number of cases, longer hospital stay, and cases paid. Blue Cross expenditures were 11.8% in excess of the subscriber income. Blue officials state there has been a cost increase of 19.6% over the previous Indemnity Program in Garfield County.

These facts and many others are confirmed in recent issues of the magazines, *Accident and Health Underwriter,* and *Accident and Sickness Review.*

The Service Plan Would Divide The Medical Profession At A Time When Unity Is A Necessity

I have noticed in recent publication various articles under the headlines: Blow-up Over Blue Shield, Blue Cross Blue Shield Jurisdictional Dispute Divides Doctors, M.D. Warns Blue Shield It's Going Too Far, etc. These headlines title many accurate and well written articles appearing in recent issues of the very popular *Medical Economics,* and other periodicals. In Wisconsin the Medical Society President resigned his position because of the bitter battle raging over the Blue Cross-Blue Shield controversy. In the last year, no less than three state medical societies, Michigan, Connecticut and Wisconsin have been rocked by major disputes over how Blue Shield has been run.

A Service Plan Will Do Irreparable Damage To The Public Relations of Medicine

Service Plans make definite and unqualified promises of complete coverage. Any failure would bring bitter dissatisfaction. The program has been sold as a "Doctor's Plan" and those that participate in the plan would be blamed for a failure, certainly not good public relations.

In some instances the public has interpreted the Service Plan as a scheme of the doctors to offer cut rate prices to a certain group. The Garfield Plan is not a plot or scheme, but it most certainly offers medical services at reduced prices to Blue Cross-Blue Shield members.

The "Doctor's Plan" of Garfield County has evoked the bitter resentment of many local insurance men who earn their livelihood from the insurance profession. The Insurance Underwriter's Association of Garfield County sent letters of protest to each member of the Garfield Medical Society and to numerous fellow insurance associations about our state. One group of local insurance men conducted an interview with the State Insurance Commissioner concerning the problem. All of which has not helped public relations of medicine in our county.

Lastly, there is a great danger that the doctor - patient relationship could be destroyed under the Service Plan. Surveys show that most patients want to pay some or all of the costs of their doctor's bills. The patient appreciates this responsibility. We must maintain the traditional concept that the individual is primarily responsible for paying for goods or services he uses. To overlook this concept is to entertain the philosophy that "some one else" is going to be responsible and if this erroneous philosophy is maintained by enough people, long enough, then it will make no difference who that someone else will be. Under the Service Plan the patient is apt to get the impression that the insurance company is paying for the doctor's service, or that his doctor has some financial arrangement with the company. This is a dangerous step in the direction of third party medicine. This "some one else" may even be the government. Lastly, if the patient becomes aware that his doctor must look to others for supervision as to the scope of care provided, the physician may lose prestige and dignity in the eyes of the patient.

A Laborer Is Worthy Of His Hire

This is one of the more important points for consideration. Repudiation of this basic concept is the heart of socialism. It is downright absurd for the lesser trained, lesser experienced worker to command the same financial gain as the skilled professional. The entire program of post graduate medical training can be destroyed. The Service Plan becomes the great equalizer when considering the physician's worth, with no regard for experience, knowledge, training, ethics, etc. True, complete confidence and the satisfaction of a job well done are deserved rewards for the more highly skilled, but let us not be too naive, financial reward is also desirable.

It Would Be Unwise To Join The "Fixed Income Group" In A Period of Inflation

The value of the dollar has decreased about 50% in the past ten years. What will happen if your income is fixed and your overhead and cost of living continue to rise? Let us suppose that 100% of your practice succumbs to Service Plan Coverage. If you participate in the program that means that your income is set and fixed 100%. Your only means of meeting rising costs would be an increased number of patients or raising fees. Increased patient load, although unlikely in an established practice, would bring further cost increase. Increased fees under the Service Plan are impossible unless premiums are raised. Think of the damage to public relations, if an increase in premiums was requested to increase the doctor's income.

The Service Plan Places A Ceiling On Your Income But Doesn't Establish A Floor

The Service Plan limits your income regardless of how well you do your work. This fact could easily cause the deterioration of good, conscientious medical care. The Service Plan leaves no latitude for the exercise of the doctor's discretion and judgment in levying fees for his services. The Service Plan does not and cannot guarantee that the participating doctor will receive the amount specified. When the income of the Service Plan falls and the demands increase, the plan will have to increase premiums, or decrease benefits, or lower the fixed fee payments to the physician. In view of the fee reductions already initiated in the Garfield County Plan, and the increased cost under the present Service Plan, I can't help but expect further fee reduction, rather than increased premiums, as the program falters.

Is A Service Plan Ethical?

The Garfield County Plan has been advertised almost to the point of ballyhoo. During the active campaign for members, no expense was spared on radio, press and the mail. Blue officials were accused of soliciting members. Full coverage was promised although few patients realized this applied only to hospitalized cases. It was advertised as approved by all doctors in Garfield County, which was not true. Some Service Plans in other areas have published lists of participating physicians.

From personal experience with the Garfield County Plan I have come to learn how a non-participating physician can be at a great disadvantage with such a program. The new doctor, particularly, will find it most difficult to maintain a practice if he doesn't participate in the local program.

A Medical Association Sponsored Service Plan Can Destroy Freedom Of Enterprise

Service Plan programs can underbid private insurance companies that operate under the free enterprise, profit making, capitalistic system which we must all agree is the foundation of our American economy. It would seem that the adoption of a Service Plan is another method to create a monopoly of health insurance and middleman control of the practice of medicine. It would seem that the Medical Profession is a party to the destruction of free enterprise by destroying private insurance companies. Medical insurance companies sponsored by doctors can be legally regarded as unfair competition. Service Plans may be in violation of the Sherman Anti Trust law. Courts might decide that "fixed fees" in medicine constitutes price fixing. Charges have been made in Oregon by the United States government against the Oregon State Medical Society. Prosecution for price fixing must be considered.

I am informed by legal consultants that here in Oklahoma the Garfield County Plan might be ruled illegal. Informants tell me that it is in violation of the Unfair Practices and Frauds Act, and Oklahoma Law ‡79. Paragraph 8 of Section 1204 of the frauds Act states that any means to induce into a contract of insurance constitutes a rebate. In the same section 1204, rebates are declared unfair methods of competition. Oklahoma Law ‡79 states that it is unlawful for any person, selling a commodity or rendering a service to the public, to discriminate between different persons by selling or rendering a service at a lower price if the effect is to establish a virtual monopoly or to destroy the competition of any established dealer in such a commodity. Our State In-

surance Commissioner states that Oklahoma Law #79 may not be applicable to the Blues Corporation, a non profit organization free of State Insurance Laws. He further states, concerning Section 1204, that rebates and unfair methods would necessitate a hearing before the Commissioner to determine if a violation has occurred.

Let us not forget that the Garfield County Full Coverage Program is the only program in the United States that offers complete coverage. Present Oklahoma laws and interpretation apply to the Indemnity Type Medical Program.

Indemnity Plans Permit The Individual To Choose The Extent Of His Insurance Coverage

Total coverage in all other fields of casualty insurance is regarded as economically unsound. Premiums for total coverage would be prohibitively high. Total medical coverage requires that all individuals pay high premiums for services which they may never require. It also requires all to pay for the abuses of the malingerer, the neurotic, and others who desire but do not need such attention.

Here, in Garfield County, the Doctor's Plan gave the insured no choice as to his insurance coverage. Blue Cross-Blue Shield members of the old indemnity plan accepted the new program or got out. He was sent a new Service Plan policy and not at his request. It is surprising how very few actually understood the program clearly.

PATRICK SHANKS, M.D.,
1800 S. Van Buren,
Enid, Okla.

Doctor Henry T. Russell was asked by the Editors to comment on Doctor Shanks' letter. His answer follows:

June 4, 1959

The Editor,
Journal, Oklahoma State Medical Association
Oklahoma City, Oklahoma.

Dear Sir:

This letter is written in answer to the letter of Doctor Pat Shanks and is an attempt to clarify some of the questions which he raises. In all fairness, it should be stated that Doctor Shanks has been strongly opposed to the service plan in Garfield County since its inception. This, of course, is his right and duty since he believes a service plan is detrimental to medicine. However many of his arguments are inaccurate, based on his lack of knowledge of the plan and many other of his arguments are simply personal opinions or opinions based on articles that favor his position. Numerous articles favoring the opposite position can be cited. In an attempt to set the record straight, I would like to discuss briefly the origin of the Garfield County Service Blue Shield Plan.

The Garfield Plan was not the brain-child of a "few" doctors as is suggested by Doctor Shanks' letter. The Garfield County Blue Cross-Blue Shield member council requested the president of the Garfield County Medical Society to consider the feasibility of such a plan. The president appointed a committee of seven doctors to study the problem and make recommendations to the Society. This committee was representative of all types of medical practitioners. The committee met numerous times (no Blue Cross-Blue Shield officials were ever present at the committee meetings) and unanimously concluded that a service plan would be desirable. The committee recommended to the Society that a service plan be developed with the Blue Shield-Blue Cross. The Society concurred and such a plan was developed. This plan was approved by 90% of the members at a regular meeting of the Garfield-Kingfisher County Medical Society. Every member had ample opportunity to express his likes and dislikes.

Doctor Shanks states that the Garfield County plan "guarantees full coverage" on medical, surgical and hospital services and is the "only program in the U. S. that offers such complete coverage." This is a gross misunderstanding on his part as to the coverage of the plan. The Blue Cross plan is no more complete that the rest of the Blue plans in the state, with the following exceptions. (1) The Garfield plan pays $12 a day instead of $6 per day on a private

room. (2) It pays hospital fees in full. (3) It pays up to $75 diagnostic X-Ray in accident cases instead of $15.

The Garfield Blue Shield Service Plan is no more complete than the state-wide indemnity plan except that the participating physicians agree to accept the scheduled fee as full payment. There is also a provision for paying consultants and surgical assistants. In general the surgical fees are slightly lower and the medical fees are slightly higher than the other Blue plans. Also in general, the fees are based on the California relative value schedule and the Oklahoma medicare schedule. There is a provision in the Garfield plan to pay 50% more than the scheduled fee for difficut or unusual cases (up to a total of 10% of a doctor's cases) and this provision has not been over utilized. Less than 2% of the total bills have requested the extra 50%. Many of our doctors have no cases requesting an additional 50%.

At the present time, only three of approximately 45 busy, active doctors in Garfield County are not participating in the plan. Any doctor may withdraw from the plan whenever he desires. It is interesting to note that the average hospital stay of patients of non-participating doctors (not including Doctor Shanks) is two times greater than the average hospital stay of patients of participating physicians. If the average stay of the patients of these men had been the same as that of the Garfield County physicians, Blue Cross would have saved over $8000 in the first six months of the program and Blue Cross utilization would have run about 105% instead of 111%. Blue Shield utilization in the first six months ran 79%.

The committee that wrote the Garfield Service Plan believed it was a good idea to try a service plan for the following reasons:

1. We believe the people want to be able to budget their medical expenses. We disagree with Doctor Shanks' contention that patients want to pay the doctor a fee in addition to paying their medical insurance premiums. Budgeting in regular monthly payments has become a fixed part of our people's financing whether we agree with it or not.

2. We do not believe in "soaking the rich." The federal government is already taking care of that. Whereas it is true that a worker is "worth his hire," it is also true that a particular service is worth just so much, regardless of who does it. It must be assumed that all physicians are capable of doing a satisfactory job in any type of procedure that they attempt. As long as there is the present balance of general practitioners and specialists, I would expect that this assumption will be continued in our medical practice. The patients themselves make the decision as to who will perform any procedure upon them. Some unusual physician may develop great skill in doing a particular procedure but is he entitled to place an extravagant fee on the service? If he does, he will end up doing his service only for the wealthy (I saw exactly this sort of thing develop in the "vagotomy" operation). This is not in the best tradition of medicine. The committee (general practitioners, surgeons, internists, etc.) try to get reasonable fees for all cases with opportunity for 50% increase in difficult cases. If a wealthy man demands more attention then his Blue Shield fee can be increased 50% but the increase is due to the increased work in the case, not merely because the man is wealthy.

The charge that the "entire program of post graduate medical training can be destroyed" by a service plan is somewhat ludicrous and I think this answers the question that most objectors raise about the service plan. Frankly it concerns money. There is a fear of limitation of income. This problem only becomes acute as our practices expand. Personally, I honestly do not know any man in medicine who entered the field of medicine to make money. If you reflect on your thoughts when you are entering medical school, how many actually thought of getting rich? Very few, if any. Of course everyone counted on a good comfortable living because practically all good doctors make such a living and will no doubt continue to do so. However the money question is only the primary reason for entering the medical field in only a very few instances. After receiving the M.D. degree how many doctors become specialists to get rich? Very few. Most specialists limit their

practice because they have a special interest or ability in a particular field or because they do not want to live the relatively more difficult life of a general practitioner. I am sure that any man who becomes an M.D. primarily for money will be sad indeed because the work is hard and the hourly pay is too low to be adequate compensation. The specialist who specialized only for the purpose of increased income will be equally unhappy. It is peculiar how our attitudes change primarily as our practice and incomes increase. Honestly now, what difference does it make what the other guy is getting as long as you individually are getting a fair price for your service? You can't take it with you. Our socialistic tax system will see to that.

A. The last paragraph of Doctor Shanks' letter states that "total medical coverage" will require all individuals to pay high premiums for services they never require and that all will have to pay for the abuses of the few. This is true of all types of insurance. Everyone always pay for the abuses of the few in every facet of our society and insurance companies are well aware of this as is evidenced by the high premiums for car insurance for drivers under 25 years of age. However, the individual cannot choose the extent of his coverage by indemnity plans because he soon discovers a few selfish doctors will raise their fees if the patient has insurance.

B. A "third party" in medicine is regretable but at least the physicians of Garfield County definitely have control of their program. This would not be true to any extent under government medicine. The cost to the patient of the Garfield plan is low enough that practically all people can afford it and we think the people will choose private coverage instead of government medicine as long as they can afford it.

Finally, the Garfield Plan was set up locally as an experimental plan. We wanted to see if we could make it work to our satisfaction and to the satisfaction of the patient. There have been many complaints from doctors and a few from patients. The committee is doing everything to try to make the necessary changes to have a good program that is paid for by the patients and run primarily by the doctors. We regret that we cannot work out a similar plan with the good commercial insurance companies who are represented by very fine agents in Garfield County. This has been impossible as most of the insurance agents here will agree. We have met with them and discussed this problem.

The committee has recommended that the Garfield Plan be changed in two ways. (1) Sell only $25 deductible Blue Cross and (2) Discontinue paying consultants (this has been the biggest problem with the doctors). If these two changes are adopted we feel that we have a very good plan that is reasonable for the doctor, relatively inexpensive but fairly comprehensive for the patient and we do think that it will help combat socialized medicine.

Sincerely,

HENRY T. RUSSELL, M.D., Chairman
Insurance Committee
Garfield-Kingfisher County Medical Society
Enid, Oklahoma

Coming Meetings

UNIVERSITY OF OKLAHOMA MEDICAL CENTER
Postgraduate Course in Medical Mycology
July 18-19, 1959 **Room 118, Medical School Building**
Oklahoma City, Oklahoma

The Department of Dermatology, University of Oklahoma Medical Center and The Oklahoma Dermatological Association will present a Postgraduate Course in Medical Mycology on July 18 and 19, 1959. This course is open to members of the Oklahoma, Arkansas, Texas and Rocky Mountain Dermatological Associations, General Practitioners of Oklahoma and Laboratory Technicians of Oklahoma. Enrollment fee for the course will be $10.00 and attendance is limited to 40 members. Complete details are available by writing to the Office of Postgraduate Education, University of Oklahoma Medical Center, 801 Northeast 13th Street, Oklahoma City 4, Oklahoma.

Oklahoma Chapter
AMERICAN ACADEMY OF GENERAL PRACTICE
September 13, 1959 **Lake Murray Lodge**
Ardmore, Oklahoma

The Sixth Annual Meeting of the Red River Valley Section, Oklahoma Chapter, American Academy of General Practice, will be held at Lake Murray Lodge, Ardmore, September 13, 1959. Participants will receive four hours credit, Category 1. For further details, write to Roger Reid, M.D., 1001 15th, N.W., Ardmore, Oklahoma.

OKLAHOMA ACADEMY OF GENERAL PRACTICE SYMPOSIUM
October 2, 1959 **Skirvin Hotel**
Oklahoma City

The Oklahoma Academy of General Practice, the University of Oklahoma Medical Center and Lederle Laboratories will present a Symposium on "Medical and Surgical Problems in the Senior Citizen," to be held October 2, 1959 in the Skirvin Hotel, Oklahoma City. Further information may be obtained by writing to Nolen Armstrong, M.D., President, Oklahoma City District, A.A.G.P., 2925 N.W. 50th, Oklahoma City, Oklahoma.

POSTGRADUATE COURSE
PREVENTION AND MANAGEMENT OF
ATHLETIC INJURIES
University of Colorado
Medical Center
Agust 10, 11, 12, 1959 **Denver, Colorado**

The third Annual Postgraduate Course on the Prevention and Management of Athletic Injuries for the Team Physician will be held in Denver, August 10, 11 and 12. Participating physicians will receive 21 hours AAGP credit (Category 1) for attending the meeting. Additional information is available by writing to the Office of Postgraduate Medical Education, University of Colorado Medical Center, 4200 East Ninth Ave., Denver 21, Colorado.

AMERICAN HEART ASSOCIATION
32nd Annual Scientific Sessions
Trade and Convention Center **October 23-25, 1959**
Philadelphia, Pennsylvania

The 32nd Annual Scientific Sessions of the American Heart Association will be held at the Trade and Convention Center in Philadelphia, October 23-25, 1959. Forms for registering and for reserving accommodations are now available from the Association, 44 East 23rd Street, New York 10, New York.

13th ANNUAL
ROCKY MOUNTAIN CANCER CONFERENCE
July 22-23, 1959 **Brown Palace Hotel**
Denver, Colorado

The Rocky Mountain Cancer Conference will be held at the air conditioned Brown Palace Hotel in Denver, July 22 and 23, 1959. Further information concerning the program and reservations may be obtained from Rocky Mountain Cancer Conference, 835 Republic Building, Denver 2, Colorado.

24th Annual Congress
INTERNATIONAL COLLEGE OF SURGEONS
September 13-17, 1959 **Chicago**

The 24th Annual Congress of the North American Federation, International College of Surgeons, will be held in Chicago, September 13-17. The federation is composed of the United States, Canadian, Mexican, and Central American Sections. For information, write to the Secretariat, International College of Surgeons, 1516 Lake Shore Drive, Chicago 10.

INTERNATIONAL COLLEGE OF SURGEONS
November 16, 17, 18, 1959 **Hot Springs, Virginia**

The Mid-Atlantic Meeting of the International College of Surgeons will be held at the Homestead Hotel, Hot Springs, Virginia on November 16, 17, 18, 1959. For further details contact: E. G. Gill, M.D., State Regent, International College of Surgeons, 711 South Jefferson Street, Roanoke, Virginia.

THE CITATION

MEDICO-LEGAL BRIEFS
Prepared by the Law Department of the American Medical Association

THE AMERICAN COLLEGE OF PHYSICIANS FILES A BRIEF IN SUPPORT OF THE DEFENDANT IN THE "CUTTER" CASE—On December 19, 1958, the American College of Physicians filed an *amicus curiae* brief in the California District Court of Appeal in the "polio" suits against Cutter Laboratories.

The College of Physicians argued, in part: "We believe that when, as in the cases before the Court at this time, a biological is made according to strict governmental specifications and complies with the best scientific and productive knowledge available, and when the manufacturer is absolved of all possible negligence by the jury, as this defendant was, no liability should be incurred when an injury occurs because of the user's own peculiar susceptibility or because of insufficient scientific knowledge at that time. To create such an absolute liability would be to saddle the world of medical science with an unfair burden." In its brief, the College of Physicians also argued that "the supplying of biologicals to a patient . . . is so closely related to the treatment by the physician that it is properly considered as part of his services. Since . . . the supplying of a certain antibiotic or vaccine is not a sale, and is so allied with the physician's professional service, it is not subject to warranties or to the Sales Act."

Amicus Curiae Brief of American College of Physicians in Support of Defendant and Appellant Cutter Laboratories. *Gottsdanker* v. *Cutter Laboratories* and *Phipps* v. *Cutter Laboratories*, 1 Civil No. 18,413 and 1 Civil No. 18,414, respectively, District Court of Appeal, State of California, First Appellate District, Division Two, Dec. 19, 1958.

DePasquale v. *Board of Regents of University*, 179 N.Y.S. 2d 239 (N.Y., Nov. 10, 1958).

RENTAL VALUE OF LIVING QUARTERS NOT TAXABLE—The United States Court of Appeals held that a physician employed by the Veterans' Administration as Chief of Professional Services at a Veterans Hospital, who for the convenience of his employer was required to accept living quarters on the employer's premises as a condition of his employment, was entitled to exclude the rental value of such premises from his gross income, regardless of whether the value of the rental quarters was considered part of his compensation.

Boykin v. *Commissioner of Internal Revenue*, 260 F. 2d 249 (C.A. 8, Oct. 30, 1958).

PHYSICIAN'S LICENSE TO PRACTICE REVOKED AFTER HE PLEADED GUILTY TO THE ILLEGAL DISPENSING OF A NARCOTIC DRUG—A physician who was licensed to practice in New York and Florida pleaded guilty to violating the Narcotic Law of Florida. He was sentenced to a prison term of three years or pay a fine of $5,000. The New York Supreme Court, Appellate Division, Third Department, upheld the New York Board of Regents revoking his license to practice. The Court held that by entering a plea of guilty in Florida to the illegal dispensing of narcotic drugs he had admitted to an offense falling within the meaning of the word "dispense" as provided in the New York Penal law, and this constituted a plea of guilty to an act which would have been felonious in New York.

Further information on the preceding cases may be obtained from the Law Department, American Medical Association, 535 North Dearborn Street, Chicago, Illinois.

Organization News

Oklahoma Medics Visit With Congressmen

A delegation of representatives of the Oklahoma State Medical Association hosted members of the Oklahoma Congressional Delegation at a breakfast on June 12 in the nation's capitol. Some members of the physician's group were returning home from the Atlantic City A.M.A. meeting, while others were in Washington to attend the First National Conference of the Joint Council to Improve the Health Care of the Aged.

Those representing the O.S.M.A. were: A. T. Baker, M.D., President of the O.S.M.A.; Hayden H. Donahue, M.D.; Chairman of the Association's Committee on Aging; John F. Burton, M.D., Member of the A.M.A. Council on Medical Service and Chairman of the A.M.A. Committee on Indigent Medical Care; Joe L. Duer, M.D., Alternate Delegate to the A.M.A.; and Don Blair, Associate Executive Secretary of the O.S.M.A. Mr. Cleveland Rogers, Executive Director of the Oklahoma State Hospital Association was also in attendance, as was Mr. James Foristel of the A.M.A.'s Washington Office.

The Oklahoma legislative delegation was represented by Senator A. S. Mike Monroney, and Representatives Tom Steed, Carl Albert, Ed Edmondson and Toby Morris. Conflicting schedules prevented Senator Robert S. Kerr and Representatives John Jarman and Page Belcher from being present.

Forand Bill Discussed

Principle topic of discussion during the informal meeting was the Forand Bill, a legislative proposal which, if enacted into law, would offer socialized medical, hospital, dental and nursing home care to over 15 million social security recipients. The bill is now resting in the House Ways and Means Committee in spite of tremendous pressure from the AFL-CIO, behind-the-scene sponsor of the legislation, to hold public hearings.

LATE DEVELOPMENT

At press time, the OSMA has learned that Representative Wilbur Mills (D. Ark.), Chairman of the House Ways and Means Committee, scheduled public hearings on H. R. 4700 beginning July 13. OSMA Federal Legislative Committee activated write-in campaign to Oklahoma members of U. S. House of Representatives.

President Baker opened the meeting by informing the legislators of the interest that Oklahoma physicians have in the health and welfare of senior citizens, as evidenced by their presence in Washington to attend the national meeting on this subject, and told them of the positive steps being taken by organized medicine to offer a free enterprise solution to the health problems of the aging in lieu of hasty, ill-conceived governmental programs. Doctor Donahue then presented a detailed roundup of the activities of the O.S.M.A. Committee on Aging, which has made much progress during the past year in evaluating the possible unmet needs of senior citizens and investigating ways of improvement through the normal channels of providing medical and health services.

In response, the legislators expressed their interest in the enthusiastic approach of organized medicine to the problem at hand. They also accepted Doctor Baker's offer to provide medical association counsel regarding Forand-Type bills by asking him for a detailed, written presentation of medicine's objections to the pending legislation and by promising to keep in close touch with the O.S.M.A. on such matters.

A Letter to Congress

In response to the congressmen's request, Doctor Baker mailed the following letter to each member of the delegation:

Dear Sir:

First, let me again express the appreciation of

the physicians of Oklahoma for the gracious hospitality extended to O.S.M.A. representatives during our recent visit to Washington. It was gratifying to sit across the table from you and the other Oklahoma congressmen and discuss our mutual problem of improving the health care of our aging population.

During the course of our informal conversation, we expressed the unified opposition of the medical profession of Oklahoma toward any Forand-type legislation which would provide health care for this segment of the population at taxpayers' expense. It was then requested that we supply each member of our congressional delegation with a detailed presentation supporting our opposition in regard to this legislation. We trust that the following remarks will enable you to be well acquainted with the position of those who are charged with the ultimate responsibility of providing health care.

The so-called Forand Bill is no more—no less than socialized medicine! The governmental provision of medical, hospital, dental and nursing home services for some 15 million Americans may be called by another name—but it still represents a major departure from our proven economic system of free enterprise.

According to Abraham Lincoln, "the purpose of government is to do for people what they cannot do for themselves." In 1950, 20% of the people of this age group had health insurance of their own. Today —only nine years later—approximately 50% are covered through the efforts of private industry and through their own commendable desire to remain independent, and, as much as possible, self supporting.

In the face of such strides through our normal channels of progress, and, in the face of increasing awareness of the growing needs of the aging group, proponents of the ill-conceived Forand Bill are declaring a national emergency and are attempting to run roughshod over Congress and the American people.

No one will deny that the accelerated growth of the aging segment of our population poses a real challenge to the health care professions and to the insurance and prepayment organizations who have contributed so much to increased longevity. It is ironic that the product of their progress is now being wielded against them by those who would destroy the free enterprise system of medical care. General economic inflation, the real villian of the old folks, should not be used as a vehicle for ruining a system that has provided our citizens with the highest health care standards of any nation in the world!

The strongest force behind compulsory health insurance is the AFL-CIO. Forand's proposal has been placed high on the union's long list of legislative wants. It's not too difficult to "crystal-ball" the next step which would be taken in the event such legislation becomes law—demands will be made upon employers for wage increases to compensate for the imposition of additional taxes. Inflation gets another shot in the arm!

Here are some additional reasons why the bill is a threat to the American people, the doctors and the hospitals:

1. **Communities would be threatened with a shortage of hospital beds.**

Under terms of the bill, beneficiaries could be lodged in hospitals and nursing institutions without charge up to 120 days each year. This could create a needless and dangerous crowding of hospital space.

In many countries where similar legislation is in effect, there has been a staggering increase in use of hospital facilities by those over 65. (In Saskatchewan, Canada, the average person over 65 occupies a hospital bed 7.2 days a year; in the United States the average person over 65 occupies a hospital bed 2.5 days a year.) Over-utilization of hospitals by social security beneficiaries would limit the number of beds available for the acutely ill of all ages.

2. **Community incentive to support and build hospitals would be curbed.**

Citizens would be inclined to shift the responsibility for building and supporting hospital facilities to the federal government and away from private and local governmental sources.

3. **Beneficiaries under the law would be restricted in their choice of hospital and physician.**

Only those hospitals and doctors entering into agreement with the federal government would participate in the program. Since a great many highly qualified doctors and hospitals would prefer to remain independent of government control, this could result in a limitation in the quality and quantity of medical facilities available to the beneficiaries.

4. **The principle of government regulation of professional fees, wages and prices would be introduced in the United States.**

Under the Forand proposal, the federal government would be given the right to fix the fees and charges to be paid to the participating physicians and hospitals. Historically, when such a principle as this is once established, it is extended to other segments of the population.

5. **It could bankrupt the social security program and jeopardize the basic retirement incomes of millions of Americans.**

There is no way of accurately predicting how much the Forand bill would cost. It could prove so costly that it would jeopardize the retirement security of millions of Americans who depend on social security for their basic retirement needs. For the first time last year, broadened benefits resulted in the social security system receiving less income than it paid out. Taxes to finance the present program are already scheduled to reach 8½% of payroll up to $4,200 in coming years.

Up to now the principle of social security has been one of cash payments to persons reaching retirement age in return for taxes paid by them and their employers during their working years. The beneficiary is free to spend his retirement income as he pleases.

Now it is proposed that eligible persons be furnished medical and hospital service instead of cash benefits, thus permitting the federal government to spend social security funds as the government wishes rather than to permit the beneficiary the right to choose how he will spend his money.

6. **It would mean higher taxes, less take home pay.**

This plan would by 1975 result in annual payments

of $228.00 by the employee and an equal sum by the employer.

The tax increases of self employed persons by 1975 could be as much as $159.75 a year. The total payment for self-employed persons would be $342.00 annually.

Any future income tax reductions would be more than offset by these social security tax increases.

7. **Demands by others for similar benefits could lead to total socialized medicine.**

The Forand bill would extend socialized medicine to the aged and would stimulate demands by other segments of the population for similar benefits. Ultimately the practice of medicine in America would be totally socialized, resulting in the inferior grade of medical care found in most countries with this system.

8. **Many aged persons would become unduly concerned with their health.**

By eliminating personal financial responsibility, many aged persons would seek unnecessary hospital and medical care for trivial and imaginary illnesses.

9. **It is hasty, ill-conceived legislation based on inadequate knowledge.**

No legislation such as the Forand bill should be considered until much more is known about the subject. No large-scale authoritative study has ever been made to determine the specific medical needs of older persons.

10. **The personal relationship between the doctor and his patient would be harmed.**

Government regulations would be imposed on patient and physician alike, bringing a third party into their personal and professional relationship. Conformance to administrative regulations could hamper the physician in prescribing treatment which in his professional opinion is indicated.

11. **The job of providing hospital and surgical services for the older population can be and should be handled through free enterprise.**

Private insurance companies have proved their ability to handle the extensive insurance needs of our growing population. Because of their experience and success in other fields, it is reasonable to allow them time to solve this additional problem—medical coverage for our citizens in the 65-and-over group.

The 50% in this age bracket who are already covered, illustrates the progress being made by the health insurance industry.

12. **It would discourage families from taking care of their own.**

Most families assist in caring for their ill, aged members. The Forand Bill would tend to destroy this traditional family responsibility and moral concept.

In summary, physicians are unalterably opposed to national compulsory health insurance—whether across the board, or limited in scope—because we believe voluntary enterprise can do the job better.

We recognize that, at the moment, there is a special need for action on behalf of the senior citizen. The precise extent and character of such need has not been clearly defined, but we know it to exist. Oklahoma physicians have recognized the problem and have undertaken a positive program to help solve it, as have other state medical societies and the American Medical Association.

We have faith in Blue Cross, Blue Shield and private insurance companies as methods of financing the cost of illness. The hard-earned success story of American medicine and its allied professions and organizations must not be scuttled in favor of legislation which would write the first chapter of an ill-fated, regressive history of regimented health care.

A positive health program for older citizens calls for an all-out approach to the needs of all the aged, sick or well, so that special needs will be less in the future . . . not greater!

The six objectives of American medicine are:

1. Creation of a realistic attitude toward aging.
2. Promotion of health maintenance programs and wider use of restorative and rehabilitative services.
3. Extension of effective methods of financing health care for persons over 65.
4. Expansion of skilled personnel training programs and improvement of medical and related facilities for older people.
5. Amplification of medical and socio-economic research in problems of the aging.
6. Leadership and cooperation in community activities for senior citizens.

Care for the older citizen calls for a cooperative approach by medical professions and facilities, insurance companies, social workers and community leaders. It requires flexibility of medical approach and technique—not the rigidity inherent in government-controlled programs.

We are determined and dedicated to work positively on behalf of older Americans through voluntary programs of all types. We are equally determined and obligated to fight proposals for compulsory health insurance in any form.

Sincerely yours,

ALFRED T. BAKER, M.D.
President

Institute of Ultrasonics In Medicine to Meet

The American Institute of Ultrasonics in Medicine will hold their Annual Meeting on September 2, 1959 at the Leamington Hotel, Minneapolis, Minnesota. The guest speaker at the Luncheon Meeting will be Russell Meyers, M.D., Professor of Surgery and Chairman, Division of Neurosurgery, State University of Iowa Hospitals and College of Medicine, who will discuss "The Potentials of Ultrasonics in General Surgery and Surgical Specialties."

For any further information contact John H. Aldes, M.D., Secretary, 4833 Fountain Avenue, Los Angeles 29, California.

REPORT OF AMA ACTIONS

The report of the A.M.A. Commission on Medical Care Plans, relations between medicine and osteopathy, the report of the Committee on Preparation for General Practice and the issue of compulsory Social Security coverage for self-employed physicians were among the major subjects which brought important policy actions by the House of Delegates at the American Medical Association's 108th Annual meeting held June 8-12 in Atlantic City.

Another highlight of the meeting was the appearance of President Dwight D. Eisenhower, who addressed an over-flow audience of more than 5,000 at the Tuesday night inauguration of Doctor Louis M. Orr of Orlando, Florida, as the 113th president of the A.M.A. It marked the first time that a President of the United States has addressed an A.M.A. annual or clinical meeting.

Doctor E. Vincent Askey of Los Angeles, speaker of the House of Delegates since 1955, was named president-elect for the coming year. Doctor Askey will succeed Doctor Orr as president at the association's annual meeting in June, 1960, in Miami Beach.

The 1959 Distinguished Service Award of the American Medical Association was voted to Doctor Michael E. De Bakey of Houston, Texas, chairman of the department of surgery at Baylor University College of Medicine, for his outstanding contributions in the field of cardiovascular surgery. Doctor De Bakey received the award at the Tuesday night inaugural ceremony.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 28,225, including 12,921 physicians.

Eisenhower Address

President Eisenhower, speaking at the inaugural ceremony in the ballroom of Convention Hall, warned that inflation posed the greatest danger to the traditional, free enterprise practice of medicine. The cost of inflation, he said, "is not paid in dollars alone but in increasingly stagnated progress, lost opportunities, and eventually, if unchecked, in lost freedoms for the doctor and the patient." Mr. Eisenhower also expressed gratification at learning of A.M.A. leadership in the program to meet the health care needs of the aged.

Commission on Medical Care Plans

The House of Delegates received Part I of the report of the Commission on Medical Care Plans as information only and then acted upon the Commission recommendations item by item. The House adopted 36 of the recommendations without change, but reworded three which relate to miscellaneous and unclassified plans. The changed recommendations now read as follows:

B-4. "In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care, study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made."

B-6. "Medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers."

B-16. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

In connection with free choice of physician, the House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of Recommendation A-7, which says:

" 'Free choice of physician' is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

Many of the Commission recommendations urged increased activity by state and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and the various types of third parties. To carry out three of the recommendations involving the A.M.A. activities, the House also approved a seven-point program which it requested the Board of Trustees to transmit to the Division of Socio-Economic Activities for immediate attention.

Medicine and Osteopathy

In considering a special report of the Judicial Council on the subject of osteopathy, the House adopted the following policy statement regarding inter-professional relations:

"(A) All voluntary professional associations between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

"(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

"(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospitals.

"(D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including inter-professional relationships on a national level."

In another action concerning osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to their staff.

Preparation for General Practice

The House approved and commended the final report of the Committee on Preparation for General Practice, which proposes a new two-year internship program for medical school graduates planning to become family physicians. To avoid unnecessary confusion, the House deleted only one sentence which read: "Indeed, the committee believes that the one year internship actually encourages inadequate preparation for general practice." The Committee on Preparation for General Practice included representatives from the A.M.A. Council on Medical Education and Hospitals, the American Academy of General Practice and the Association of American Medical Colleges.

The suggested program would include a basic minimum of 18 months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. A physician then could elect to spent the remaining six months for additional training in other segments of the program. The committee stated, however, that participants who plan to practice obstetrics would be expected to spend at least four months of the elective period in obstetrical training.

The report declared that "the graduate program of two years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for ade-

quate experience in outpatient care and emergency room service.

Social Security

In considering five resolutions on the subject of compulsory Social Security coverage for self-employed physicians, the House disapproved of four and adopted one reaffirming its opposition to the compulsory inclusion of physicians. In so doing, the delegates expressed concern over the possible effects that a change of policy might have on the Association's entire legislative program, particularly with respect to the Forand Bill.

The House also recognized "the apparent growing demand by physicians for economic security" and requested the Board of Trustees to investigate the possibilities of developing group insurance and retirement plans which could be made available to Association members. It accepted a reference committee suggestion "that the American Medical Association continue and expand its educational program to inform its members of the economic, social and moral advantages of economic security obtained within the framework of our free enterprise system rather than through the mechanisms of governmental Social Security."

Miscellaneous Actions

In dealing with a wide variety of other subjects, the House also: Urged all physicians to participate more fully in community activities and *socio-economic matters* in their own communities but agreed that no change should be made at this time in Article II of the Constitution, which states Association objectives;

Approved in principle the aims and objectives of the President's Council on *Youth Fitness* and the Citizens Advisory Committee on the Fitness of American Youth;

Accepted a Board of Trustees recommendation that the *1962 Annual Meeting* be held in Chicago;

Expressed heartfelt thanks to the Committee on *Amphetamines* and Athletes, which has completed its assignment;

Requested the Board of Trustees to study the problems and possibilities of establishing an A.M.A.-sponsored *medical scholarship* and/or loan program;

Approved the inclusion of *Today's Health* as a benefit of dues-paying membership and urged members to make it available to their patients;

Recommended that state medical societies, where advisable, initiate legislative efforts to eliminate *cancer quackery;*

Received a progress report indicating "phenomenal progress" in the field of health insurance coverage for *the aged* since the Minneapolis meeting last December;

Gave a rising vote of thanks to *Doctor Joseph D. McCarthy,* who finished his term as chairman of the Council on Medical Service;

Reaffirmed its full support of the Educational Council for *Foreign Medical Graduates;*

Endorsed the purposes outlined in the initial report of the *Medical Disciplinary Committee;*

Urged every A.M.A. member to give a substantial gift to the *medical schools* through the American Medical Education Foundation; and

Expressed appreciation for the outstanding *disaster medicine* program presented by the United States Army Medical Service on June 6, 1959, in Atlantic City.

Opening Session

At the Monday opening session Doctor Gunnar Gundersen of La Crosse, Wis., retiring A.M.A. president, stressed the personal responsibility of every physician to keep abreast of medical advancements and to deliver "1959 medicine." Doctor Orr, then president-elect, called for concerted effort and medical leadership in four areas—the costs of medical care, recruitment of dedicated medical students, basic research and health care of the aged. Doctor Carl V. Moore, Busch professor of medicine at Washington University, St. Louis, was presented with the eighth Goldberger Award in clinical nutrition. Smith, Kline and French Laboratories of Philadelphia received a special A.M.A. award for its sponsorship of

color medical television over the past ten years.

Inaugural Ceremony

Doctor Orr, in his Tuesday night inaugural address, affirmed his belief in the basic principles of medicine, democracy and faith under which America's physicians live. He pointed out that freedom must continually be fought for by men and women who are willing to stand up and be counted. Doctor Leonard Larson of Bismarck, N. D., A.M.A. Board Chairman, administered the oath of office to Doctor Orr, and the latter presented the Distinguished Service Award to Doctor De Bakey. The Fort Dix Band Chorus presented the muscial program.

Election of Officers

In addition to Doctor Askey, the new president-elect, the following officers were selected at the Thursday session:

Vice president, Doctor James Stanley Kenney of New York City; speaker of the House of Delegates, Doctor Norman A. Welch of Boston, and vice speaker, Doctor Milford O. Rouse of Dallas, Tex.

Doctor R. B. Robins of Camden, Ark., and Doctor Hugh H. Hussey Jr. of Washington, D. C., were re-elected for five year terms on the Board of Trustees. Also elected to the Board, for the first time, was Doctor Percy E. Hopkins of Chicago.

Doctor J. M. Hutcheson of Richmond, Va., was re-elected to the Judicial Council. Re-elected to the Council on Medical Education and Hospitals were Doctor Charles T. Stone Sr. of Galveston, Tex., and Doctor W. Andrew Bunten of Cheyenne, Wyo.

Doctor Willard Wright of Williston, N. D., was elected, and Doctor J. Lafe Ludwig of Los Angeles was re-elected to the Council on Medical Service. Doctor William Hyland of Grand Rapids, Mich., was re-elected to the Council on Constitution and Bylaws.

Date Set for Southeastern Oklahoma Clinical Symposium

The McAlester Clinic Foundation and the University of Oklahoma School of Medicine, Department of Post Graduate Education will present the Fifth Annual Southeastern Oklahoma Clinical Symposium in McAlester, August 8-9, 1959.

The program will consist of scientific papers, clinical presentations and panel discussions.

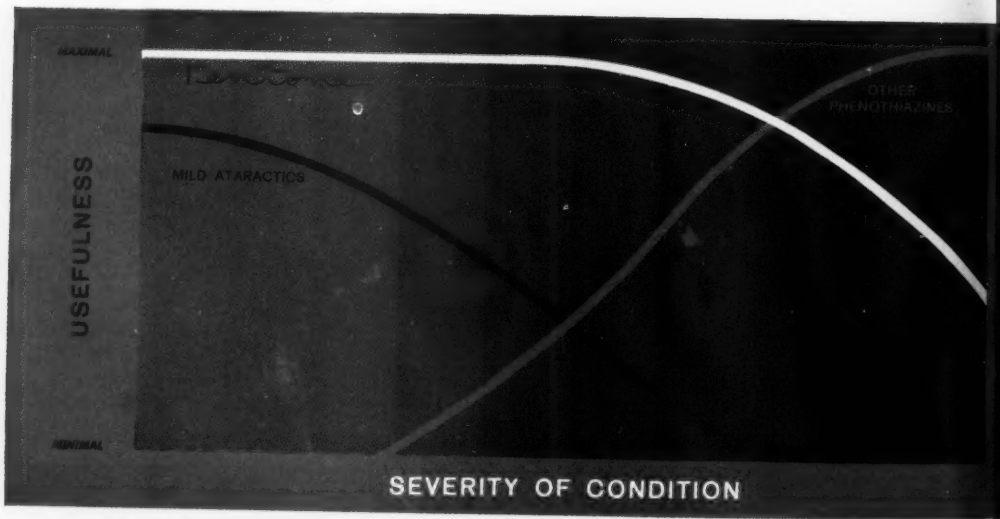
Guest speakers for the two-day meeting and their subjects will be: Willis E. Brown, M.D., Professor of Obstetrics and Gynecology, University of Arkansas School of Medicine, Little Rock, Arkansas, "Management of Eclampsia" and "Female Urology"; Joseph White, M.D., Department of Anesthesiology, University of Oklahoma School of Medicine, "Toxic Reactions to Local Anesthetic Drugs" and "Recent Advances in Anesthesia".

Also speaking will be John J. Schilling, M.D., Department of Surgery, University of Oklahoma School of Medicine, "New Developments in Homotransplantation" and "Deceleration Injury"; Robert Furman, M.D., Oklahoma Medical Research Center, "Nutritional Modification of Hormonal Influence On Serum Lipids: 1. Dietary Protein and Androgen, 2. Corticosteroids and Calories"; Harris D. Riley, Jr., M.D., Department of Pediatrics, University of Oklahoma School of Medicine, "Collagen Disease in Childhood" and "Aseptic Meningitis"; Thomas S. Gafford, M.D., Pathologist, Muskogee, "Functional Cysts of Ovary—Introgenic Ovarian Failure"; and Allen E. Greer, M.D., Assistant Professor of Surgery, University of Oklahoma School of Medicine, "Open Heart Surgery."

A complete program and reservations may be obtained by writing to Charles A. Miller, Business Manager, McAlester Clinic, Third and Seminole Streets, McAlester, Oklahoma.

new... highly effective tranquilizer ...

Comparison of TENTONE usefulness



zer ... for extended office practice use

Tentone

Methoxypromazine Maleate

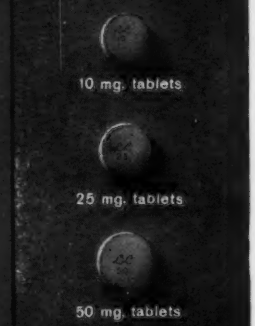
LEDERLE

NEW PHENOTHIAZINE COMPOUND FOR THE LOWER AND MIDDLE RANGE OF DISORDERS

◆ Positive, rapid calming effect in mild and moderate cases. ◆ Striking freedom from organic toxicity, intolerance, or sensitivity reaction—particularly at low dosage. ◆ Greater freedom from induced depression or drug habituation. ◆ May be useful, as with other tranquilizers, to potentiate action of analgesics, sedatives, narcotics. ◆ Facilitates management of surgical, obstetric, and other hospitalized patients. ◆ Indicated when more than a mild sedative effect is desired...and less than psychosis is involved. ◆ Dosage range: *In mild to moderate cases:* from 30 to 100 mg. daily. *In moderate to severe cases:* from 75 to 500 mg. daily.

LEDERLE LABORATORIES, a Division of **AMERICAN CYANAMID COMPANY,** Pearl River, New York

Supplied



Endocrine Society Names Turner as Schering Scholar

The American Endocrine Society has named Henry H. Turner, M.D., Oklahoma City, as this year's Schering Scholar. The award was presented to Doctor Turner during June 5 ceremonies held in conjunction with the annual meeting of the organization in Atlantic City.

An anonymous committee of the Council of the Society selected the Oklahoman for the $2500 grant on the basis of his accomplishments as an established investigator in the fields of endocrinology. The cash award is made possible through the generosity of the Schering Corporation and is presented annually to a deserving physician who wishes to extend the opportunities for his work either here or abroad.

Doctor Turner has announced that he intends to utilize the grant by attending both the 1960 International Goiter Conference, London, and the International Congress of Endocrinology, to be held in Copenhagen the same year. While abroad, he will also visit with a number of well-known European investigators.

In addition to being the Schering Scholar, he is also holding the office of Secretary-Treasurer for the national organization. Other current activities of national importance in which he is engaged include service as Associate Editor of the Endocrinology Section of the Cyclopedia of Medicine and his recent installation as President of the National Society of Nuclear Medicine.

New Pamphlet Aids in Nursing Home Selection

A new pamphlet entitled, "Need Help in Selecting a Nursing Home?" has been prepared by the Hospital Division of the State Department of Health. The printed piece is designed to assist older citizens, as well as those who advise them, in the proper selection of a home to fit their particular needs.

Readers are advised to evaluate such considerations as liscensure, living space, cleanliness, availability of adequately trained personnel, appearance of other patients, costs, special services (such as dietary), and compatability of other occupants, before making a selection. Most of all, they are advised to visit several such institutions before making any arrangements.

The pamphlet should prove a useful tool to physicians who are frequently ask for recommendations regarding nursing home facilities in their communities. A limited supply of the brochures is available through the health department by contacting Norma Schaefer, c/o Hospital Division, 3400 North Eastern, Oklahoma City. To cover printing costs, the pamphlets are sold at five cents each.

Larger quantities may be obtained from Mrs. Marjorie Magee, Secretary, Oklahoma Nursing Home Association, 2307 S. W. 27th Street, Oklahoma City.

Tulsa's New Doctors Building Opened

The new seven-story Doctors Building at 21st and Lewis Streets, in Tulsa, was opened last month. Erected at a cost of $1,500,000, the structure provides offices for fifty-three medical doctors and four dentists.

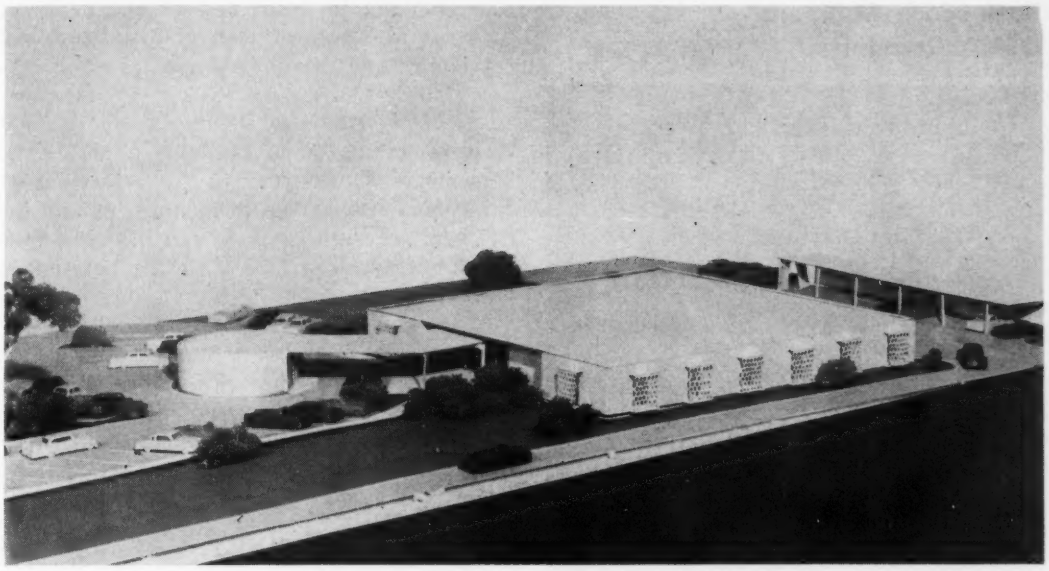
Among the facilities in the new building are two radiology laboratories, three pathology and bacteriology laboratories, a pharmacy, optician and coffee shop.

Work on the 65,000 square foot unit which was begun fifteen months ago was financed by its tenants through the self-owned Twenty-first Street Building Corporation, and is managed by the Fifth and Boston Corporation, a subsidiary of the First National Bank and Trust Company.

Of contemporary design, the building has walls of insulated porcelain steel panels, with structural columns and windows covered with aluminum. It is completely air-conditioned and uses a specially engineered type of heating equipment to meet the needs of multiple examination and treatment rooms. Each suite is designed to the individual requirements of the tenant. A modern decor is emphasized by the use of utilitarian furniture and equipment.

A parking area east of the building provides parking for patients and visitors. A second lot located west, across Lewis Avenue accommodates cars of doctors and office personnel.

Architects for the building were Murray, Jones and Murray.



Chickasha Clinic Plans New Building

Work will begin soon on the new Chickasha Clinic to be located on a two acre site directly west of the new Grady Memorial Hospital. The one-story structure of approximately 11,200 square feet will provide space for eleven doctors.

Of modern design, the clinic will be constructed with eight inch brick which will form both interior and exterior walls around the perimeter. A double corridor in the physicians' area will eliminate unnecessary traffic and insure privacy. Exterior windows will be covered by a concrete solar screen.

Each physician will have a consultation room with two treatment rooms. The specialties will be situated in the clinic to be close to the ancillary services that will be necessary in each physcian's type of practice.

Included in the over-all plan is space for a diagnostic x-ray suite, a clinical laboratory, emergency room, physical therapy room and a specially designed electrocardiographic room which is being constructed with certain protective lining in the walls, with current provided by a battery system to insure accurate ECG tracings. The administrative department will include a large public lobby plus five smaller waiting areas.

A separate pharmacy building to be located in the front of the clinic will be joined by an overhead structure. Adjacent to the building will be parking space for 75 automobiles.

Architects for the clinic, which is scheduled for completion in December 1959, are Brauer and Wood of Chickasha. It will be built by Walter Nashert Construction Company, Oklahoma City.

Kerr to Oppose Social Security for Doctors

Senator Robert S. Kerr has informed the OSMA office that he will continue to vote against inclusion of physicians in the Social Security program as a result of the final tabulation of a poll of Oklahoma physicians which he recently conducted.

Of the 1207 physicians voting by questionnaire, 728 voted against participation as compared to 479 who favored the proposal. In addition to those voting for or against the program, the survey revealed that nearly 100 physicians are participating by reason of employment or business associations.

R. H. Lynch, M.D., and OSMA Recognized

R. H. Lynch, M.D., (right) is shown receiving a resolution expressing the gratitude and appreciation of the House of Representatives of the State of Oklahoma from Representative Jim Cook, Wilburton.

A resolution taking note of the contributions and services of R. H. Lynch, M.D., Hollis, and the Oklahoma State Medical Association, expressing the gratitude and appreciation of the House of Representatives of the State of Oklahoma, was recently presented to Doctor Lynch. Presentation of the resolution was made by Representative Jim Cook, Wilburton, of the House Committee on House Administration.

The resolution read as follows:

WHEREAS, Doctor R. H. Lynch of Harmon County, Oklahoma, at considerable personal inconvenience and sacrifice, left his practice and his interests in his home community to minister to the health of Members of the Twenty-seventh Session of the Oklahoma Legislature; and

WHEREAS, His service and professional attentions to the Members of the House of Representatives during this, the Twenty-seventh Oklahoma Legislature, have been outstanding in every respect and have reflected the highest degree of professional training and capability; and

WHEREAS, The Oklahoma Medical Association has made available a list of its members subject to call for treatment of the Members of the Legislature during the Twenty-seventh Session, and has otherwise voluntarily cooperated with this Legislature to an outstanding degree; and

WHEREAS, It is therefore appropriate that this Legislature express its gratitude and appreciation to Doctor Lynch and to the Oklahoma Medical Association for these services and courtesies.

NOW, THEREFORE, BE IT RESOLVED BY THE HOUSE OF REPRESENTATIVES OF THE TWENTY-SEVENTH LEGISLATURE OF THE STATE OF OKLAHOMA:

That this House, now duly assembled, does hereby express its sincere appreciation and gratitude to Doctor R. H. Lynch for his outstanding services as physician to the Membership of this House during this Legislative Session, and does hereby extend its sincere thanks to the Oklahoma Medical Association for the services and courtesies extended by that organization during this Session; and

BE IT FURTHER RESOLVED That properly prepared copies of this Resolution be presented to Doctor Lynch and the Oklahoma Medical Association.

Adopted by the House of Representatives the 2nd day of June, 1959.

CLINT G. LIVINGSTON,
Speaker of the House of Representatives

J. HOWARD EDMONDSON,
Governor of the State of Oklahoma

Method in Our Madness?

All of us these days are constantly asked to complete forms and submit data until we are sorely tempted to dump most of it in "file 13." The industrial physician is no stranger to this problem. He realizes, perhaps more acutely than his colleagues who are engulfed in therapeutics, that careful answers to worthwhile questionnaires are often most rewarding, though not infrequently pay-dirt may be inapparent for a number of years.

Physicians associated with industries —part time or full time—have a unique opportunity and obligation to pursue long-term follow-up studies on these relatively stable populations. The effect of increasingly complex environmental factors on the human organism, progression of various disease states under known work exposures, effectiveness of handicapped workers and socio-economic and medico-legal problems are a few of the fields in need of continued exploration. Much of the data for these studies is derived, not by the direct work of a few, but by the cooperation of many submitting accurate data via the ubiquitous questionnaire.

In the complexities of our age every physician sooner or later practices Industrial Medicine, and awareness of the far reaching importance of these problems will make the general practitioner's questionnaire and report chore easier and add vastly to our total of accurate knowledge.

Prepared by OSMA Committee on Occupational Medicine

provides therapeutic levels . . . for 24 hours . . .
with low incidence of sensitivity reactions . . .
WHENEVER SULFAS ARE INDICATED
KYNEX
Sulfamethoxypyridazine Lederle
0.5 Gm. TABLETS/NEW ACETYL PEDIATRIC SUSPENSION
LEDERLE LABORATORIES, a Division of
AMERICAN CYANAMID COMPANY, Pearl River, New York

Book Review

A WOMAN DOCTOR LOOKS AT LOVE AND LIFE. Marion Hilliard, M.D.; Doubleday and Company, Inc., Garden City, New York, 1957, pg. 181. Price $2.95.

This is a book for women by a woman who knows them. The author, an obstetrician for over 25 years, covers the gamut of woman's emotional and sexual life, from adolescence through the child-bearing years, the menopause and old age. She deals especially effectively with two of women's worst bugaboos, fear and fatigue.

The style is breezy and easy to read. The message is clear, incisive and forthright, the result of the author's years of experience and insight.

Gynecologists and obstetricians should enjoy reading this little book and it should be required reading for their patients.—*Sylvia Onesti Richardson, M.D.*

Auxiliary News

National Delegates

Organizational plans for the year were completed at the thirty-sixth annual convention held in Atlantic City in June. Serving Oklahoma as delegates were: Mrs. Pat Fite, Sr., Muskogee; Mrs. Ray M. Balyeat, Mrs. Joseph W. Kelso, and Mrs. Neil W. Woodward, of Oklahoma City. Alternate delegates were: Mrs. Don H. O'Donoghue, Oklahoma City; Mrs. Thomas H. Davis, Mrs. Frank J. Nelson, and Mrs. W. A. Showman, of Tulsa. Mrs. Clifford M. Bassett was State Presidential Delegate and served as Chairman of State Delegates.

Membership and Personal Service

Too often the American Medical Auxiliary membership roster of 80,000 is appraised with an optimistic eye. This national figure is but one-half the number of doctors who are members of A.M.A. State-wise, our Auxiliary membership is 1,150, as compared with 1,608 members of the Oklahoma State Medical Association.

Why statistics? With ever-increasing need for awareness of existing medical trends, growing pains in services at community level, and leadership needed in so many service projects, membership evaluation is obvious. Often the criticism is made that Medical Auxiliaries spread themselves "too thin"; that, instead of concentrating on large projects which receive more publicity and recognition, we tend to undertake the smaller, less glamorous service projects. The last two words explain much about Auxiliary. We *are* a service group; we extend the aims and objectives of our county, state and national medical societies. We are not a fund-raising organization. As a service group, we realize the need for personal services, whether extended as a unit or on an individual basis.

"Organized Community Voices"

At a recent V.N.A. meeting, Mrs. Guy Fraser Harrison, vice-president of the Board of Directors, made the following statement: "Public health practices have been directly affected by the advances made in scientific knowledge and understanding. Perhaps the most significant is the growing recognition that the community has a voice in determining what health services should be provided. There are now 'organized community voices' that are demanding better, not just adequate, health services with emphasis on personalized and comprehensive care." Physicians' wives can, and must, play an important role in this development of "organized community voices."

This role begins at home, in personal and public contacts, in the neighborhood, the P.T.A., eventually including every health service in our community; opportunity is unlimited for interested and well-informed Auxiliary members.

Can Hours Be Counted?

We were asked last year to keep a record of the number of hours spent in community service. Few Auxiliary members did. Regularly clocked hours in hospitals or institutions can be counted; other services are difficult to "time." When one member was praised for her work in teaching swimming to polio patients, she said, "That was just something I knew I could do." One county president made an excellent report on members' activities. When congratulated, she said, "In our town people know that as doctors' wives we will head civic drives, health drives, and assume any responsibility in the community that we can. They always call on us." Simply stated—but can hours be counted?

Rapidly decreasing rural areas present increasing health problems. Here the wife of a doctor has continual responsibilities. Likewise, in crowded urban areas, health problems zoom with the population; and our services are badly needed. Regardless of the size of the community, our responsibilities constantly advance, our opportunities for service increase—so must our interest and our membership.

Deaths

Lea A. Riely, M.D.
1874-1959

Lea R. Riely, M.D., who practiced medicine in Oklahoma for 52 years, died June 14, 1959 in New Canaan, Connecticut.

A native of Indiana, Doctor Riely graduated from the University of Louisville School of Medicine in 1898, coming to Oklahoma City the following year. Doctor Riely taught at the University of Oklahoma School of Medicine from 1907 until 1945. At the time of his retirement in 1951, he had practiced medicine in Oklahoma City longer than any other physician.

Doctor Riely was a member of the American Board of Internal Medicine and the American College of Physicians. In 1951, he was honored for his years of service to the medical profession when the Oklahoma State Medical Association made him an Honorary Member.

William Arthur Fuqua, M.D.
1880-1959

William Arthur Fuqua, M.D., 79-year-old Grandfield physician died in Wichita Falls, Texas on May 19, 1959.

Born in Buck Lodge, Tennessee in 1880, Doctor Fuqua moved to Altus in 1888. He graduated from Tulane University of Medicine in 1910. He had served the medical profession for 52 years in Grandfield.

Doctor Fuqua was a member of the Oklahoma State Medical Association and the American Medical Association.

Ellis Lamb, M.D.
1878-1959

Ellis Lamb, M.D., pioneer Clinton physician and former President of the Oklahoma State Medical Association in 1928-29, died June 14, 1959.

A native of Paragould, Arkansas, Doctor Lamb graduated from Memphis Hospital Medical College in 1905. He began his practice in Clinton in 1907 where he practiced continuously for over 52 years.

In 1958, the Oklahoma State Medical Association honored Doctor Lamb with the presentation of an Honorary Life Membership and a 50-Year Pin for his years of service to the medical profession.

Doctor Lamb was a Fellow of the American College of Physicians and a member of the American Board of Internal Medicine.

Alfred Hilliary Hathaway, M.D.
1871-1959

Alfred Hilliary Hathaway, M.D., retired Mountain View physician, died in May, 1959.

A native of Bells, Tennessee, Doctor Hathaway received his medical degree from the University of Arkansas School of Medicine in 1905. He had practiced in Mountain View since 1908.

In addition to his membership in the Southern Medical Association, Doctor Hathaway was honored in 1949 when the Oklahoma State Medical Association presented him a membership in the 50-Year Club, commemorating half a century of medical practice. In 1951, he was again recognized by O.S.M.A. when he was awarded a Life Membership in appreciation for his years of service to the medical profession.

Dennis S. Downey, M.D.
1878-1959

Dennis S. Downey, M.D., 80-year-old Chickasha physician, died in Oklahoma City June 28, 1959.

Born in Clinton County, Missouri, Doctor Downey graduated from the University of Louisville School of Medicine in 1908. Later that year he began his practice in Chickasha.

In 1951, Doctor Downey was honored when the Oklahoma State Medical Association presented him with a Life Membership in recognition of his contribution to the medical profession.

25 YEARS AGO

Articles published in *The Journal* of the Oklahoma State Medical Association July, 1934.

TREATMENT OF EARLY SYPHILIS

Carl L. Brundage, M.D., Oklahoma City

I will give my method of continuous treatment for early syphilis in otherwise healthy young adults, which is similar to the method of Keidel. This was first introduced at Johns Hopkins' syphilis clinic in 1916, but did not appear in current medical literature until 1926. This method has recently been adopted by the cooperative clinical group.

Primary Syphilis: Sero-negative or sero-positive stage, regardless of sex: The first injection of neo-arsphenamine 0.3 gm., increase to 0.6 gm. on the third and sixth day; repeat the latter dosage every five to seven days until ten injections have been given, then the alternating of bismuth salicylate in oil, grains two, intramuscularly, with the neo-arsphenamine for two weeks. Stop arsphenamine, give bismuth intramuscularly twice weekly for four weeks.

Second Course: Same as first, except increasing the course of bismuth from four to six weeks.

Third Course: Same as second, except completing the treatment with sixteen injections of bismuth twice weekly.

Secondary and Early Latent Syphilis: Preparation of the patient with mercury cussinimide, grains 1/6, intramuscularly on three successive days preceding the initial injection of neo-arsphenamine; continuation of the first, second and third course the same as the primary stage, except the addition of the iodides, grains three, three times daily for two weeks preceding each course of neo-arsphenamine.

Fourth Course: The neo-arsphenamine administered the same as the third course. Mercury succinimide, grains 1/6, intramuscularly five times weekly instead of bismuth for a period of eight weeks. Stop treatment if patient is free of all clinical manifestations of syphilis, and all serological tests have been negative during treatment. Encourage the patient as to his excellent chance of a radical cure, but insist on a yearly physical examinaion and blood Wassermann test.

Have You Heard?

HOLICE POWELL, M.D., is joining the staff of the Buell-Myers Clinic in Okmulgee. A graduate of the University of Tennessee College of Medicine, Doctor Powell is moving to Okmulgee from Arkansas where he has been instructor in Obstetrics-Gynecology at the University of Arkansas Medical Center.

HARVEY ELKOURI, M.D., Anadarko, is moving to Chickasha where he will be associated with B. B. MCDOUGAL, M.D. Doctor Elkouri graduated from the University of Oklahoma School of Medicine in 1954.

GRADY N. COKER, M.D., a native of Georgia, has joined the medical staff of the Broadway Clinic and Hospital in Shawnee. Doctor Coker graduated from the Medical College of Georgia in 1954 and spent three years in OB-GYN residency at the Medical College of Georgia Hospitals.

CHARLES A. CARMACK, M.D., formerly in practice in Okemah, is now associated with O. H. PATTERSON, M.D., in Sapulpa. Doctor Carmack is a graduate of the University of Oklahoma School of Medicine.

CEYLON S. LEWIS, JR., M.D., Tulsa, assumed the presidency of the Oklahoma State Heart Association at its annual meeting on June 6 in Oklahoma City. He succeeds WILLIAM BEST THOMPSON, M.D., Oklahoma City.

JAMES W. KELLEY, M.D., President of Tulsa County Medical Society, has been elected a member of the American Association of Plastic Surgeons, a national organization whose membership is limited to fewer than 100 specialists. Doctor Kelley appeared by invitation at the annual meeting of the group in Boston last month when he presented a paper on "Treatment of Sacrococcygeal Teratoma."

PHYSICIAN PLACEMENT

General Practice

Johnny Bill Delashaw, 1905 1st Avenue, N., Texas City, Texas, age 25, married, graduated from University of Texas Medical Branch, 1959, will be available upon completion of internship, July, 1960.

Louis E. Harrington, M.D., Danbury, Iowa, age 37, married, graduated from Wayne University College of Medicine, Detroit, Michigan, 1949, veteran, will be available September, 1959.

John Leland Hudson, M.D., 9 Anna Sue Road, Van Buren, Arkansas, married, graduated from the University of Arkansas, 1955, veteran, available since April 7, 1959.

James Edward Lynsky, M.D., 2054 11th Street, Cuyahoga Falls, Ohio, age 33, married, graduated from Ohio State School of Medicine, 1957, veteran, will be available July 1, 1959.

Robert Emmett Myers, M.D., 872 Ravine Drive, Cleveland 12, Ohio, age 28, married, graduated from University of Arkansas, 1955. Would like to do general practice with emphasis on pediatrics, veteran, will be available September, 1959.

Peter Pappas, Jr., M.D., 513 N. Louise Street, Atlanta, Texas, age 35, married, graduated from University of Texas, 1954, veteran, will be available July 1, 1959.

Wyatt Bibb Pouncey, M.D., 118 Louise Lane, San Mateo, California, age 34, married, graduated from University of Alabama, 1950, veteran, available immediately.

Robert Glenn White, Jr., M.D., 431 Saratoga, San Antonio, Texas, age 26, married, graduated from University of Oklahoma, 1956, presently in military service, will be available August 2, 1959.

Thomas S. Whitecloud, M.D., 858 Market Street, Pascagoula, Mississippi, age 45, married, graduated from Tulane, 1943, veteran, has an interest in teaching and wishes to get into small hospitl work, availability date depends upon situation.

Gerald C. Zumwalt, M.D., 1701 Avenue P, Del Rio, Texas, age 27, married, graduated from University of Oklahoma, 1956, veteran, will be available July, 1959.

Internal Medicine

William S. Harrison, M.D., 2623 Pittsfield Blvd., Ann Arbor, Michigan, age 31, married, graduated from University of Oklahoma School of Medicine, 1953, veteran, will be available September 1, 1959.

Doss O. Lynn, M.D., 6101 16th Street, N.W., Washington 11, D.C., age 47, married, graduated from University of Oklahoma, 1937, board certified in internal medicine and cardiology, will have completed 21 years active service September 1, 1959, prefers institutional or industrial practice, will be available after September 1, 1959.

Vanis Pennington, M.D., 1440 W. Bethune, Apt. 402, Detroit, Michigan, age 30, married, graduated from University of Tennessee, 1953, veteran, will be available December, 1959.

John H. Prodell, Jr.; M.D., 115 South Mall, Willow Lawn, Richmond 30, Virginia, age 38, married, graduate of Harvard, 1947, veteran, will be available July 1, 1959.

Locum Tenens

Frank H. Cooper, M.D., will complete internship at St. John's Hospital, Tulsa, on July 1. Would like to have locum tenens in general practice for two weeks, available any time after July 1.

B. Anthony Linn, M.D., Veterans Administration Hospital, 4500 S. Lancaster Road, Dallas 16, Texas, will finish residency in Ophthalmology in July, graduate of the University of Oklahoma, 1956, licensed to practice in Oklahoma, would like to have a locum tenens for two weeks during the summer of 1959.

Don Allen Mills, M.D., 3911 Burns Place, S.E., Washington, D.C., age 34, married, veteran, graduated from Georgetown University School of Medicine, 1958, wants to do general practice for two years prior to specialized training. Will be available July 1, 1959.

Neurology

Kenneth C. Duncan, M.D., St. Luke's Hospital, Chicago, Illinois, age 30, married, graduated from the University of Oklahoma, 1955, veteran, will be available July, 1959.

Obstetrics and Gynecology

Robert Lee Crews, M.D., 5040th USAF Hospital, Anchorage, Alaska, age 31, married, graduate of Vanderbilt, 1954, board eligible, will be available July, 1960, upon completion of military service.

Gerald R. Keilson, M.D., Medical Arts Building, Dallas, Texas, age 31, married, graduated from University of Texas, 1953, board qualified, veteran, will be available in July of 1960.

Milton Gardner Mutch, Jr., M.D., 423 Mills Avenue, Fargo, North Dakota, age 31, married, graduated from University of Minnesota, 1955, will be Board eligible upon completion of fellowship, veteran, will be available July 1, 1959.

Otolaryngology

Joseph E. Walthall, M.D., 1673 West Broadway, Anaheim, California, age 37, married, graduated from Duke University, 1946, board certified in Otolaryngology, veteran, will be available in approximately three months.

Pediatrics

Prentiss Edwards Findlay, M.D., 1500 Wakefield Place, New Orleans 22, Louisiana, age 29, married, graduated from Emory University, Atlanta, 1954, noneligible for military service, will be available July 15, 1959.

Radiology

Thomas A. Lynch, M.D., 7009 N. 17th Street, Tacoma, Washington, age 39, married, graduated from University of Washington, 1950, board certified, veteran, availability date depends on circumstances of new position.

Surgery

(Name on Request) 32 years old, married, graduated from Tulane, 1952, veteran, board eligible in surgery.

Valerio J. Federici, M.D., 2401 West Toronto Street, Philadelphia, Pennsylvania, age 36, married, graduated from Jefferson Medical College, 1948, veteran, is now available.

Owen Foster Kline, Jr., M.D., 4712 Warrington Drive, Flint, Michigan, married, graduated from University of Colorado, 1954, not eligible for military service at the present time, will be available July 1, 1959.

General Surgery

Frank L. Lanuti, M.D., 215 S. Randall Avenue, Madison 5, Wisconsin, age 38, married, graduated from University of Illinois, 1953, board eligible in general surgery, veteran, will be available July 1, 1959.

Clyde William Draughon, M.D., McGuire Hospital, Box 27, Richmond, Virginia, age 35, married, graduated from University of Oklahoma School of Medicine, 1954, veteran, will be available July 1, 1959.

Sam Leslie Robinson, M.D., University Medical Center, Jackson, Mississippi, age 30, married, graduated from University of Tennessee, 1953, will be available July, 1961, on completion of residency.

Tuberculosis

Helen C. Sharp, M.D., 620½ N. Broadway, Pittsburgh, Kansas, single, graduated from University of Kansas, 1928, prefers to do industrial or student health work and is presently available.

Urology

Wilbern W. Wersich, M.D., 1008 McIndoe, Wausau, Wisconsin, age 38, married, graduated from Northwestern University, 1951, board eligible, veteran, will be available in the near future.

MISCELLANEOUS ADVERTISEMENTS

FOR SALE: Numerous new and used items for furnishing a medical office. Includes a consultation chair, mayo, castle sterilizer, steel clothes locker, examining table, miscellaneous instruments and laboratory glassware, X-ray apron and gloves and an oxygen regulator. Excess to my needs—in good condition. W. A. Waters, M.D., 4926 E. 21st, Tulsa.

FOR SALE: Two story frame physician's office building, and equipment Britton. Centrally air-conditioned, living quarters above and two rental apartments in rear, plus two adjacent lots. Contact Key D, The Journal, Oklahoma State Medical Association, P. O. Box 9696, Oklahoma City, Oklahoma.

TO SUB-LET: Six months beginning August, 1959, lease then available for five years. Suite 860 square feet. Frew Building. 528 N.W. 12th, William Best Thompson, M.D.

FOR SALE: Hamilton Pediatric table #9888, tan finish, grey upholstery, new condition. Worden walnut consultation room furniture, new condition. Also used equipment sufficient to equip small office. Contact W. P. Jeter, M.D., 912 S.W. 50, ME 2-1556, Oklahoma City.

WANTED: Late model Electrocardiograph. Write Key B, The Journal, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

BARGAINS—in medical equipment, new and used. Largest stock of good used medical devices in the Southwest. Reconditioned and guaranteed. We buy, sell, trade, rent, repair. Examining and operating tables beautifully refinished, rechromed, reupholstered. Tell us about your equipment problems. TeX-RaY Co., opposite St. Paul's Hospital, 3305 Bryan Street, Dallas, Texas.

REGISTERED LABORATORY TECHNICIAN: Major oil company in progressive southwestern community of 25,000 has opening for female registered laboratory technician for complete clinical laboratory. 40-hour work week. Excellent employee benefits. Give education, experience, and salary requirements in initial letter and include photograph. Write Key F, THE JOURNAL, Oklahoma State Medical Association, P.O. Box 9696, Oklahoma City, Oklahoma.

FOR SALE: One 220 KV Westinghouse Deep Therapy X-ray Unit, complete with complete set of treatment cones, including intermediate therapy cone set and release treatment stretcher. Price: $5,000. Owner may be contacted via CE 2-5501 or P.O. Box 1825, Oklahoma City, Oklahoma.

Proceedings of the 53rd Annual Session of the House of Delegates of the Oklahoma State Medical Association, April 19, 1959

Closing Session

The Closing Session of the 53rd Annual Session of the House of Delegates of the Oklahoma State Medical Association was called to order by the Speaker of the House, Doctor Clinton Gallaher, at 5:00 p.m. in the Pompeian Room at the Mayo Hotel in Tulsa.

The Credentials Committee reported a quorum was present.

Doctor Gallaher called for additional introduction of guests, announcements and committee reports. None were forthcoming.

The Chair then called for a report from the Constitution and By-Laws Committee. The Chairman, Doctor William T. Gill, reported that last year an amendment to the Constitution had been presented to the House of Delegates and was now ready to be acted upon. This amendment pertained to the adding, at the end of Article VIII, Section 5 of the Constitution, the following sentence:

"If the office of President-Elect becomes vacant, the President shall immediately call a special session of the House of Delegates for the purpose of filling the vacancy by election."

After reading this amendment, Doctor Gill moved the adoption of the amendment to the Constitution. The motion was seconded and carried.

Next, Doctor Gill presented an amendment to Chapter 1, Section 4.02 of the By-Laws which was as follows:

"HONORARY LIFE MEMBERS. Any physician, a member of this Association, who by reason of ill health or age shall retire from the active practice of medicine, or who has engaged in the active practice of medicine for fifty years or more, and/or whose service to humanity and his profession has been conducted with dignity and honor may be placed on the Honorary Life membership roll. Eligibility for such consideration is limited to those physicians who have been members of this Association not less than five years immediately preceding the application, and whose petition for such membership is initiated by a component society, and approved by the Council prior to that annual meeting."

Following the presentation of this amendment, Doctor Gill moved that Chapter I, Section 4.02 of the By-Laws be amended by adding the word "or" after the word "and" in line five. The motion was seconded and carried.

The next amendment to be considered by the House was to Chapter VIII, Section 3 of the By-Laws by adding the following words to the end of the sentence: " . . . who are residing in the State of Oklahoma."

Before action was taken on this amendment, Doctor Gill explained that this section of the By-Laws pertained to the Grievance Committee which consists of the five living past presidents. He further explained that since Doctor H. M. McClure, President in 1957, had moved out of the state, there was a vacancy on this Committee. Doctor Gill then moved that Chapter VIII, Section 3 of the By-Laws be amended by replacing the period at the end of the sentence with a comma to add the words "who are residing in the State of Oklahoma." The motion was seconded and carried.

At this time, the Chair recognized Doctor E. C. Mohler, President of the Association. Doctor Mohler extended his gratitude to the House of Delegates, the Council, Committees, Committee Chairman and the entire medical Association for their help and cooperation during his term of office, and following his remarks, he received a standing ovation.

Doctor Gallaher announced that the next order of business would be the election of officers.

The first office to be filled was that of PRESIDENT-ELECT. The candidates for this office were Walter E. Brown, M.D., and Clinton Gallaher, M.D., nominated in the opening session. Doctor Gallaher called for further nominations and a motion was made that nominations cease. The motion was seconded and upon being put to vote, the motion carried, and the nominations were closed.

Doctor Gallaher announced that the vote for President-Elect would be by ballot, and requested that the tellers come forward.

The Speaker turned the Chair to J. Hoyle Carlock, M.D., to conduct the election.

Following the voting and the tabulating thereof, the Chair advised that Walter E. Brown, M.D., Tulsa, was elected to the office of President-Elect of the Oklahoma State Medical Association.

The next office to be elected was that of VICE-PRESIDENT. Charles E. Green, M.D., Lawton, was nominated in the opening session. Doctor Carlock called for further nomination. Subsequently, a motion was made that nominations cease and Doctor Green be elected by acclamation. The motion was duly seconded and carried.

Malcom E. Phelps, M.D., El Reno, was re-elected to the office of Delegate to the A.M.A. in the same manner, as was R. Q. Goodwin, M.D., for the office of Alternate Delegate to the A.M.A.

The next order of business was the election of Councilors for Districts Nos. 1, 3, 4, 7, 10, and 13. The Speaker pointed out that, as had been commented on in the opening session, since Doctor Charles Green

of Lawton had been elected Vice-President, it would be necessary for District #13 to submit another nomination in Doctor Green's place. . . . W. R. Cheatwood, M.D. of Duncan, was nominated.

The Speaker also called for an additional nomination from Councilor District No. 4, to take place of the nomination of Joe L. Duer, M.D., Woodward. Doctor John X. Blender, Cherokee, was nominated.

This completed the nomination of Councilors. The following Councilors were elected by acclamation:

DISTRICT 1—J. E. Highland, M.D., Miami
L. B. Word, M.D., Bartlesville
DISTRICT 3—George T. Ross, M.D., Enid
DISTRICT 4—Walter H. Dersch, M.D., Shattuck
John X. Blender, M.D., Cherokee
DISTRICT 7—C. C. Young, M.D., Shawnee
E. K. Norfleet, M.D., Bristow
DISTRICT 10—Paul Kernek, M.D., Holdenville
C. E. Lively, M.D., McAlester
DISTRICT 13—J. B. Miles, M.D., Anadarko
W. R. Cheatwood, M.D., Duncan

Following the election of officers, the Chair recognized Doctor Seth D. Revere of Chickasha who recommended that in view of the change in By-Laws that H. M. McClure, M.D., Past President, be added to the Honorary Life Membership Roll. After discussion, the House recommended that Doctor Revere put this application in writing to be submitted to the Council and House of Delegates for action at their next session.

Doctor Revere then recommended that the By-Laws be suspended for the purpose of re-introducing the name of H. M. McClure, M.D., for Honorary Life Membership. The House ruled that the By-Laws could not be suspended and, therefore, the previous recommendation would have to remain in effect.

Doctor Carlock turned the Chair to Doctor Gallaher after the completion of the election.

The next order of business was a report from the RESOLUTIONS COMMITTEE. Doctor Gallaher called on Doctor C. M. Hodgson, Kingfisher, Chairman of the Committee for this report.

As the first Resolution, Doctor Hodgson read the following, which had been recommended to the Resolutions Committee by the delegates from the Garfield-Kingfisher County Medical Society and had been prepared by the Resolutions Committee.

Resolution

WHEREAS, the Garfield-Kingfisher County Medical Society recognizes the contributions to the Oklahoma State Medical Association and his community that have been given by Henry T. Russell, M.D., Enid, and,

WHEREAS, Doctor Russell because of personal considerations finds it necessary to resign from the Council of the Oklahoma State Medical Association,

NOW, THEREFORE, BE IT RESOLVED, That the Oklahoma State Medical Association, in convention assembled, expresses to Doctor Henry T. Russell its appreciation for the efforts, time, and abilities that he has given to this profession while serving as a member of the Council of the Oklahoma State Medical Association.

GARFIELD-KINGFISHER
COUNTY MEDICAL SOCIETY

Doctor Hodgson reported that the Resolutions Committee recommended the adoption of this Resolution, and its was so moved by Doctor Hodgson. The motion was duly seconded and carried.

The next Resolution to be presented was prepared by the Resolutions Committee in regard to HB No. 820:

Resolution

WHEREAS, the Oklahoma State Medical Association has had brought to its attention HB 820 of the Oklahoma Legislature, introduced by Representative Forsythe of Tulsa, which would establish a Medical Examiners System, contra-wise to the Coroner's System.

NOW, THEREFORE, BE IT RESOLVED, that the House of Delegates of the Oklahoma State Medical Association, in convention assembled on the 19th day of April, herewith endorses and supports the intents of the Legislator.

OKLAHOMA STATE MEDICAL ASSOCIATION

Doctor Hodgson moved the adoption of this Resolution. The motion was duly seconded and carried.

Next on the agenda was the Resolution submitted by the Carter County Medical Society, extending Associate Membership in the Oklahoma State Medical Association to Doctor Thomas M. McCoy, Ph.D., Director of The Noble Foundation of Ardmore:

Resolution

BE IT RESOLVED THAT:

WHEREAS, Doctor Thomas M. McCoy, Ph.D., Director of the Noble Foundation of Ardmore, Oklahoma, and,

WHEREAS, Doctor McCoy has made such momentous contributions in the field of cancer research and established himself and The Noble Foundation as a source of authority in the field of nutrition;

NOW, THEREFORE, BE IT RESOLVED, that the Oklahoma State Medical Association recognizes the contribution Doctor McCoy has made in the field of cancer research and herewith extends to him an Associate Membership in the Oklahoma State Medical Association; and,

BE IT FURTHER RESOLVED, that the Oklahoma State Medical Association recognizes and compliments

The Noble Foundation for the outstanding work being done toward Cancer Research in the field of nutrition, to the end that its research will add materially to the ultimate eradication of cancer.

CARTER COUNTY MEDICAL SOCIETY

Doctor Hodgson moved the adoption of this Resolution. The motion was duly seconded and carried.

The next Resolution to be considered was submitted by the Oklahoma Society of Anesthesiologists, as follows:

Resolution

WHEREAS, the development of a service plan of insurance payments gives the insuring group a chance to set fees for the medical profession, and

WHEREAS, this allows pressure to be exerted by lay organizations on the medical profession, now

BE IT RESOLVED, that the Oklahoma Society of Anesthesiologists go on record as opposing.

OKLAHOMA
SOCIETY OF ANESTHESIOLOGISTS

Doctor Hodgson reported that the Resolutions Committee had considered the Resolution of the Oklahoma Society of Anesthesiologists with reference to a service-type plan of insurance.

Inasmuch as this theory of care has been embodied in the report of the Committee on Insurance for Senior Citizens, the Resolutions Committee feels that it should defer action on this Resolution until such time as the House of Delegates either rejects or accepts the report of the Committee on Insurance for Senior Citizens.

Doctor Hodgson moved the adoption of the deferment of a decision on this Resolution. The motion was duly seconded and carried.

The last Resolution to be considered was submitted by the East Central County Medical Society with regard to the A.M.A. dues, as follows:

Resolution

WHEREAS, At the present time only nine component state medical Associations in the United States, including the Oklahoma State Medical Association, have a mandatory requirement of membership in the American Medical Association for their members, and,

WHEREAS, In the forty other states membership in the American Medical Association and payment of the annual dues therein is optional with the individual member, and,

WHEREAS, A sizeable proportion of physicians in the forty states elect not to belong to the American Medical Association, and,

WHEREAS, The failure of these forty Associations to assume their just share of the obligations and responsibilities of the national organization places a disproportionate burden upon the remaining nine associations with compulsory A.M.A. membership requirements, and

WHEREAS, No effective effort to correct this situation has been made by the American Medical Association,

NOW, THEREFORE, BE IT RESOLVED, That the Council recommend to the House of Delegates of the Oklahoma State Medical Association that effective with the calendar year of 1960, membership in the American Medical Association shall be optional with the individual physician member, and

BE IT FURTHER RESOLVED, That the Council initiate the necessary amendment to the By-Laws to repeal the compulsory A.M.A. membership requirement, and

BE IT FURTHER RESOLVED, That such action be taken as a protest to the failure of the forty component state associations to assume their due obligations to the American Medical Association, to encourage a uniform solution to this inequitable and lamentable situation, and that in no way be it considered a reflection upon the present progressive program being pursued by the American Medical Association, its officers and employees.

Enacted at regular meeting East Central Oklahoma Medical Society, December 10, 1958.

(Signed) G. L. BERKENBILE, M.D., Secretary

Doctor Hodgson reported that the Resolutions Committee rejects this Resolution for the reason that they believe it is not in the best interest of organized medicine to create further controversy within the organization.

Doctor Hodgson moved the adoption of this rejection. The motion was duly seconded and carried.

Doctor Gallaher called for any other announcements or business. There was no further business.

The new officers were asked to come to the front for introduction.

The meeting of the House of Delegates was declared adjourned at 6:05 p.m.

REPORTED BY:

MARGARET BARTON
MARY MARGARET BOWEN

VESPRIN made the difference

SQUIBB TRIFLUPROMAZINE HYDROCHLORIDE

in anxiety and tension states / psychomotor agitation / phobic reactions / obsessive reactions / senile agitation / agitated depression / emotional stress associated with a wide variety of physical conditions

In the patient with anxiety and tension symptoms — Vesprin calms him down without slowing him up... and does not interfere with his working capacity. Vesprin permits tranquilization *without* oversedation, lethargy, apathy or loss of mental clarity.[4]

And Vesprin exhibits an improved therapeutic ratio — enhanced efficacy with a low incidence of side effects; no reported hypotension, extrapyramidal symptoms, blood dyscrasia or jaundice in patients treated for anxiety and tension.[1,2,3]

dosage: for "round-the-clock" control — 10 mg. to 25 mg., b.i.d.; for "once-a-day" use — 25 mg. once a day, appropriately scheduled, for therapy or prevention. **supply:** Oral Tablets, 10, 25 and 50 mg., press-coated, bottles of 50 and 500; Emulsion (Vesprin Base) — 30 cc. dropper bottles and 120 cc. bottles (10 mg./cc.). **references:** 1. Stone, H.H.: Monographs on Therapy *3*:1 (May) 1958. 2. Reeves, J.E. Postgrad. Med. *24*:687 (Dec.) 1958. 3. Burstein, F.: Clinical Research Notes *2*:3, 1959. 4. Kris, E.: Clinical Research Notes *2*:1, 1959. "VESPRIN" is a Squibb Trademark

Vesprin — the tranquilizer that fills a need in every major area of medical practice

SQUIBB
Squibb Quality —
the Priceless Ingredient